NTUC Income Insurance Co-operative Limited
Income Centre 75 Bras Basah Road Singapore 189557
Tel: 6788 1777 · Fax: 6338 1500
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an NTUC Social Enterprise

Checklist for Medical/Accident/Living/Total and Permanent Disability Claim (Individual and Group Life/Medical Policies)

Dear claimant

We are sorry to learn of your illness/injury/hospitalisation. In order for us to process your claim, we require the following (please tick 'V' the appropriate box and enclose the required documents):

Important notes

(a) All items must be duly completed to avoid delay in the claim processing. Please indicate as "N.A." if not applicable.
(b) We encourage you to opt for Direct Crediting under the Payment Method section of the claim form for payment to reach you faster.
(c) Upon receipt of ALL the required documents, we will process your claim and inform you of the outcome as soon as possible.
(d) All overseas documents must be certified as true copies by your lawyer or any Notary Public.
(e) All documents submitted must be in English. Any documents which are in foreign languages must be officially translated to English by a certified translator/ interpreter.
(f) Please continue to pay the premiums to keep your policy in force.

☐ **Total and Permanent Disability Claim/Terminal Illness Claim/Disability Care**

_____ Medical/Accident/Living/Total and Permanent Disability Claim Form (to be completed by claimant)

_____ NRIC or relevant identification documents (e.g. passport, birth certificate) of claimant

_____ Attending Medical Practitioner's Statement (AMPS) (to be completed by attending doctor & submitted to us)

_____ Medical reports/Laboratory reports/Hospital Discharge Summary

_____ Medically boarded out letter (where applicable)

_____ Newspaper clipping and Police/Accident Report (if Total & Permanent Disability or Permanent Incapacity was due to accidental or violent causes)

_____ Termination letter from last employer OR CPF Statement showing last employment contribution (for DPS policy only)

_____ CPF Contribution Statement for the past 15 months (for DPS policy only)

_____ Latest pay slip of insured (for group policies)

_____ Dependant Booster Benefit Claim Form (for Family Protect policy only), to be completed by claimant

☐ **Dread Disease (Living) Claim/Female Illness/Senior Illness/Juvenile Illness**

_____ Medical/Accident/Living/Total and Permanent Disability Claim Form (to be completed by claimant)

_____ NRIC or relevant identification documents (e.g. passports, birth certificates) of claimant

_____ Attending Medical Practitioner's Statement (AMPS) (to be completed by attending doctor & submitted to us)

_____ Medical reports/Laboratory reports/Hospital Discharge Summary

Note: Please use the specific AMPS form if claimant is claiming under the following medical conditions:
Cancer/Major Cancers, Benign Brain Tumour, Kidney Failure, Stroke, Heart Attack/Coronary Artery By-pass Surgery/Angioplasty and Other Invasive Treatment for Coronary Artery, Heart Valve Surgery/Percutaneous Valve Surgery, Parkinson's Disease, Surgery to Aorta/Large Asymptomatic Aortic Aneurysm.

☐ **Medical Claim**

☐ **Incomeshield (Non-Integrated - where premiums are not paid using CPF funds), Family Plus, Annuity Hospital & Surgical, Managed Healthcare System (Inpatient)**

_____ Medical/Accident/Living/Total and Permanent Disability Claim Form (to be completed by claimant)

_____ ORIGINAL Final hospital/medical bills & receipts

_____ Hospital discharge summary

_____ Medical reports, if available

_____ A copy of the settlement letter from the Insurer/Employer (If there is previous reimbursement from another Insurer/Employer)

☐ **Hospital Benefit (Rider)/Hospital Cash Benefit**

_____ Medical/Accident/Living/Total and Permanent Disability Claim Form (to be completed by claimant)

_____ A copy of the Final hospital bills

_____ Hospital discharge summary

_____ Medical reports, if available

_____ Medical Certificates, if available

☐ **Accident Claim (Accident Benefit)**

_____ Medical/Accident/Living/Total and Permanent Disability Claim Form (to be completed by claimant)

_____ Hospital discharge summary

_____ Medical Certificates

_____ A copy of the Final hospital bills & receipts

_____ Medical reports

_____ Accident reports

_____ Police Report, if any

☐ **Retrenchment Benefit**

_____ Medical/Accident/Living/Total and Permanent Disability Claim Form to be completed by claimant (to complete these sections: Policy number, Plan Type, Particulars of Insured, Other Information, Payment Method, Declaration and Authorisation)

_____ Retrenchment letter from employer stating reason(s) for the retrenchment

_____ CPF Statement showing last 6 months' contribution prior to retrenchment and cessation of contribution for at least 3 months after retrenchment

☐ **Maternity 360**

_____ Medical/Accident/Living/Total and Permanent Disability Claim Form (to be completed by claimant)

_____ NRIC or relevant identification documents (e.g. passport, birth certificate) of claimant

_____ Medical reports/Laboratory reports/Hospital Discharge Summary

_____ Child's birth certificate (for claim on child's benefit)

_____ Child's health booklet (for claim on child's benefit)

_____ A copy of the final itemised/detailed hospital bills

Please submit all claim documents at any of our branches[2], OR through your insurance adviser, OR by post to:

Claims Service Centre
NTUC INCOME Insurance Co-operative Limited
75 Bras Basah Road
INCOME Centre
Singapore 189557

For Group Insurance Policies, Public Officers Group Insurance Scheme (POGIS) and Corporatised Entities Group Insurance Scheme (CEGIS), please submit your documents through your company.

[2] Please refer to our website **www.income.com.sg** for the location and opening hours of our branches. If you need any assistance, please contact our Customer Service Officers at **6788 6616** or email us at **csquery@income.com.sg**.

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Medical/Accident/Living/Total and Permanent Disability Claim Form (Individual and Group Life/Medical Policies)

Important Notice
The acceptance of this form is NOT an admission of liability on the part of Income. Any documentary proof or report required by Income shall be furnished at the expense of the policyholder or claimant (depending on plan types). To avoid delay in processing your claim, please submit the duly completed claim form together with the supporting documents within 30 days from date of occurrence.

Claim Type (For Individual life policies only) – Please tick '✓' the appropriate box:

☐ Accident Benefit	☐ Disability Care
☐ Dread Disease Benefit	☐ Female Illness/Senior Illness/Juvenile Illness Benefit
☐ Hospitalisation Benefit	☐ Maternity 360
☐ Retrenchment Benefit	☐ Others _____
☐ Total and Permanent Disability Benefit/Terminal Illness Benefit	

Policy number(s)	Plan type	Claim number

Particulars of insured

Name of insured (as shown in NRIC/PP)	NRIC/Passport/Birth Certificate number	Gender ☐ Male ☐ Female
Occupation (If unemployed, please indicate last occupation)	☐ Employed ☐ Self Employed ☐ Unemployed	Date of birth (dd/mm/yyyy)
Name and address of employer or last employer (if unemployed)	Period of employment (dd/mm/yyyy) From _____ To _____	
Name of policyholder (if different from insured)	NRIC number	Gender ☐ Male ☐ Female
Address		
Contact number (Office) (House) (Hand phone)	Email	

For Accident/Disability claims only

1. a. Date the insured last worked (dd/mm/yyyy) : _____

   b. Date the insured returned to work (dd/mm/yyyy) : _____ OR

   Date the insured expect to return to work (dd/mm/yyyy) : _____

Medical Condition/History

2. Details of illness/injury

Is the condition/disability suffered due to ☐ Illness ☐ Accident

a. If the condition/disability suffered is due to illness, please provide

(i) Diagnosis _____

(ii) Date symptoms started (dd/mm/yyyy) _____

(iii) Describe in detail all symptoms and nature of medical condition/disability suffered.

Medical Condition/History (continued)

b. If the disability suffered is due to accident, please provide

(i) Date of accident (dd/mm/yyyy) _____ (ii) Time of accident _____

(iii) Place of accident _____

(iv) Detailed description of nature of injuries/disability suffered

(v) Detailed description of accident (Please enclose a copy of the police report, if any)

c. (i) Please state the periods of hospitalisation

Name of hospital	Period of hospitalisation	
	From (dd/mm/yyyy)	To (dd/mm/yyyy)

(ii) Has the insured been given hospital/medical leave? ☐ Yes ☐ No

If "Yes", please state the start and end date of the hospital/medical leave.

Start Date (dd/mm/yyyy) _____ End Date (dd/mm/yyyy) _____

3. How was the insured admitted to the hospital?

☐ Referral by a General Practitioner/Specialist/Other hospital (please delete accordingly)

Please provide the name and address of referring doctor/hospital.

_____

_____

☐ A & E department

4. Please provide the name, contact number and address of the doctor who is treating the insured for his current condition/injury.

5. Was surgery performed for this condition? If "Yes", please provide details below. *(For Medical/Accident claims only)* ☐ Yes ☐ No

Surgical operation/procedure	Date(s) of operation/procedure (dd/mm/yyyy)	Surgical code/table (please refer to your doctor)

Medical Condition/History (continued)

6. Has this or similar condition/injury been treated before? If "Yes", please provide details below. ☐ Yes ☐ No

Name of doctor	Name and address of clinic/hospital	Date(s) of consultation (dd/mm/yyyy)	Reason(s) for consultation

7. Has the insured seen other doctors besides those indicated above? If "Yes", please provide details below. ☐ Yes ☐ No

Name of doctor	Name and address of clinic/hospital	Date(s) of consultation (dd/mm/yyyy)	Reason(s) for consultation

8. Please provide details of the insured's regular doctor(s) and company doctor(s) below:

Name of doctor	Name and address of clinic/hospital	Date(s) of consultation (dd/mm/yyyy)	Reason(s) for consultation

Other insurances

9. Is the insured covered for medical expenses by any other insurance company (ies), his employer or any other parties? If "Yes", please state details below. ☐ Yes ☐ No

10. Is the insured claiming from any other insurance company (ies) or other sources (employer, other medical insurances, Workmen's Compensation Act) in respect of this condition/injury? If "Yes", please provide the following information. ☐ Yes ☐ No

Name of employer, Insurance company etc.	Policy number	Date of issue (dd/mm/yyyy)	Type of plan	Claim amount	Claim notified (Yes/No)	Claim paid (Yes/No)

For medical claims, please provide a copy of the respective settlement letter from the other insurance company or other sources.

Note: It is important to inform us if you are claiming from other insurance companies, your employer or any other parties for the same bill. You can only claim or be reimbursed for the amount that you have incurred regardless of the number of medical insurance policies you may have. We reserve the right to recover the excess amount paid to you.

Other information

11. Has the claimant been bankrupt or insolvent or has executed any deed or transfer for the benefit of creditors since becoming interested in the policy? If "Yes", please provide details.

Policyholder ☐ Yes ☐ No Details: _____

Assignee ☐ Yes ☐ No Details: _____

Donee/
Court Appointed Deputy ☐ Yes ☐ No Details: _____

Insured ☐ Yes ☐ No Details: _____

Payment method

Please tick one of the boxes below to indicate payment method:

☐ Credit into my personal bank account (Please submit a copy of your bank book or statement for account verification. You need to circle the account for crediting if your statement shows more than 1 bank account) - We encourage you to opt for Direct Crediting for payment to reach you faster.

☐ Cheque to be mailed directly to the claim recipients

☐ Cheque to be collected by financial adviser

Name of adviser _____

Adviser code _____

Personal data use statement

By providing the information and submitting this form, I/we give my/our consent to NTUC Income Insurance Co-operative Limited, its representative, agents (collectively "Income"), relevant third parties, referred to in Income's Privacy Policy which can be found at https://www.income.com.sg/privacy-policy and/or appointed distribution partners to collect, use, and disclose the information (including any updates) for the purposes of processing and administering this insurance application or transaction, providing me with financial advice and/or recommendation on products and services, managing my relationship and policies with Income including research and data analytics, and in the manner and for the purposes described in the Income's Privacy Policy.

Where personal data of a third party (for example information of my spouse, child, ward or parent) is provided by me/us, I/we represent and warrant that I/we have obtained the consent of the third party to provide you with their personal data for this application or transaction.

The consent provided by me in this form is in addition to and does not supersede any consent which I may have provided previously in respect of the above purposes, unless my consent is withdrawn and notified to Income.

Please refer to Income's Privacy Policy for more information, including access and correction of my personal data and consent withdrawal.

Declaration and authorisation

1. I certify that the information in this form is true and complete and I have not withheld any material information.
2. I confirm that I understand and agree to the 'Personal data use statement'.
3. For the purposes of policy administration including processing and investigating this claim, and deciding whether Income is to insure or continue to insure me for my insurance applications or policies,
   a. I authorise any person or organisation who has relevant information pertaining to this claim, including any medical practitioner, health care provider or institution, insurance company, and investigative agencies, to release and exchange such information (including personal health information) requested by Income and/or its claims service providers.
   b. I authorise Income and its claims service providers to collect, use, disclose and to exchange with the persons or organisations listed above any information (including personal health information).
   c. I am authorised to disclose information (including personal health information) about the insured person if this claim is made on behalf of them.
4. I consent to the transfer and disclosure, at any time and without notice or liability to me, of any medical information on me in the insurer's possession to the Central Provident Fund Board for:
   a. the purpose of making a claim under the Dependant's Protection Insurance Scheme or any other insurance scheme referred to in the Central Provident Fund Act (Chapter 36) which I may be insured under; or
   b. any purpose connected with the administration or operation of the accounts maintained by the Board for me under the Central Provident Fund Act (Chapter 36).

   In addition, I hereby agree that this consent shall remain valid notwithstanding my death.
5. I also understand that the claim benefit that I will be receiving under Dependants' Protection Insurance Scheme, subject to the approval of my claim application, will be the sum assured that I was covered for as at the date when my incapacity commenced as stated in my medical certification.
6. I agree that a photocopy or electronic version of this authorisation shall be as valid as the original.

Name and signature/thumbprint of policyholder (individual)		NRIC/Passport number	Date (dd/mm/yyyy)
Name and signature/thumbprint of insured who is 21 years old or above (if different from policyholder)		NRIC/Passport number	Date (dd/mm/yyyy)
Name and signature of claimant who is 21 years old or above (if the policyholder/insured does not have the mental capacity or is below 21 years old)	Relationship to policyholder	NRIC/Passport number	Date (dd/mm/yyyy)
Please indicate why policyholder/insured is unable to sign			

For group policyholders only	
Name of member/employee (if different from insured)	NRIC/Passport number
Name of company/union	Address of company/union
Date joined company/union (dd/mm/yyyy)	
Last drawn salary	Date of last drawn salary (dd/mm/yyyy)
Please furnish a certified true copy of the Insured member's latest pay slip (for a full month).	
Name of authorised officer	Contact number
Signature	Date (dd/mm/yyyy)
Company/Union Stamp	
Payment to be made to ☐ Company/Union (please complete payment mode above) ☐ Member/Employee (including payment into Medisave account) ☐ Others, please specify _____ Name (as shown in NRIC) and NRIC/Passport number	