Income Insurance Limited I UEN: 202135698W
Income Centre 75 Bras Basah Road Singapore 189557
Tel: 6788 1777 · Fax: 6338 1500
Enquiries: www.income.com.sg/enquiry

Dear Customer, please email your claim to groupclaim@income.com.sg to avoid delay in the processing.

Checklist for Group Living/Total and Permanent Disability Claim

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) Upon receipt of ALL the required documents, we will process your claim and inform you of the outcome as soon as possible.
(c) All overseas documents must be certified as true copies by your lawyer or any Notary Public.
(d) 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.
(e) Please continue to pay the premiums to keep your policy in force.

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

_____ Group 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)

_____ Latest pay slip of insured (for group policies)

☐ **Dread Disease (Living) Claim**

_____ Group 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.

Submission of documents

For Group Insurance Policies, please submit your documents through your company.

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Group Living/Total and Permanent Disability Claim Form

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 email the duly completed claim form together with the supporting documents to groupclaim@income.com.sg within 30 days from date of occurrence.

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

☐ Dread Disease Benefit ☐ Total and Permanent Disability Benefit/Terminal Illness Benefit

Policy number(s)	Plan type	Claim number

Particulars of insured

Full Name of insured (as shown in NRIC, FIN or Passport)	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 Disability claims

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: _____

Payee's details

Payment to be made to ☐ Company ☐ Others, please provide details below

Name of bank _____ Branch _____

Account number _____

[2] If you provide us with an inaccurate bank account number under this section for the payment of this claim, we shall discharge from all liability under under this claim and not be liable for any losses incurred by you (Please submit a copy of bank book or statement for account verification).

Name of payee (as shown in the bank account)	NRIC, FIN or Passport number (as shown in the bank account)	Relationship to the insured	Nationality	Country of residence

Personal data use statement (A photocopy of this authorisation is valid as an original copy)

By providing the information and submitting this application or transaction, I/we consent and agree to Income Insurance Limited ("Income"), its representatives, agents, relevant third parties, Income's appointed insurance intermediaries and their respective third party service providers and representatives (collectively "Income Parties") (referred to in Income's Privacy Policy at http://www.income.com.sg/privacy-policy) to collect, use, and disclose any personal data in this form or obtained from other sources, including existing personal data provided and any future updates, (collectively "personal data") for the purposes of processing and administering my/our insurance application or transaction, providing me/us with financial advice and/or recommendation on products and services, managing my/our relationship and policies with Income including sending me/us corporate communications and notices on updates and servicing, research and data analytics, and in the manner and for the purposes described in Income's Privacy Policy.

Where the personal data of another person(s) (for example, personal data of my family, employee, payee/payer or beneficiary) is provided by me/us or from other sources to Income Parties, I/we represent and warrant that:

- I/we have obtained their consent for the collection, disclosure and use of their personal data; and
- I am/we are authorised to give any authorisation, approval and consent on their behalf to collect, use or disclose, their personal data,

for the purposes as set out in this Personal Data Use Statement.

For the purpose of this application and any claim in connection with my/our policy(ies) with Income, I/we also authorise, agree and consent to (whether this application or transaction is accepted or refused) the following:

a) The medical source, insurance office, reinsurer, or organisation to release to Income any medical or relevant information to do with me or the insured;
b) Income to collect from and/or disclose to any medical source, insurance office, reinsurer, or organisation any medical or relevant information to do with me or the insured; and
c) Income or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests for Income to underwrite and evaluate me or the insured health status or condition in relation to this application and any claim in connection with my/our policy(ies) with Income.

When submitting a claim for an insurance policy, I/we consent and agree that the personal data will also include any subsequent information collected on health or any information that is necessary for Income to decide whether to pay the claim, such as test results, medical examination results, and health records from medical sources such as medical examiners or laboratories.

I/We authorise, consent and agree to the following:

- Income Parties to collect from and/or disclose to the group policyholder, the personal data for all the relevant purposes listed above and in Income's Privacy Policy including to respond to enquiries from the group policyholder for the purposes of this application and policy servicing matters, including confirmation of eligibility for the cover; and
- The group policyholder to disclose the personal data to Income Parties for all the relevant purposes listed above and in Income's Privacy Policy.

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

Declaration and authorisation

I certify that the information in this form is true and complete and I have not withheld any material information.

I confirm that I understand and agree to the collection, use and disclosure of my personal data as stated in the 'Personal data use statement' (PDUS) above.

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.

I confirm that all documents submitted to Income including bills and invoices are copy of the original documents and I am aware that I am required to retain all original documents for a period of 6 months from claim submission date for verification by Income when required. I am aware that Income may reject my claim should it discover that the document(s) that I have submitted is not a copy of the original document(s).

I confirm that I have paid in full all the bill(s)/invoice(s) that I have submitted to Income for reimbursement and I have not made any claim and will not make any claim from any other source for the same bill(s)/invoice(s). If I have made a claim from other source, I agree that I will provide a copy of the settlement agreement between me and such other source. I am aware that Income will not reimburse me if I have received a full reimbursement from any other source. If I do not receive full reimbursement from other source, I am aware and understand that Income will only reimburse me the balance of the bill/invoice that has not been paid to me by other source. In the event Income has made a reimbursement to me and I have claimed from other sources and be reimbursed for more than what I incurred in total, I agree that Income has the right to recover any payment made by Income to me.

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 employee (if different from insured)	NRIC/Passport number
Name of company	Address of company
Date joined company (dd/mm/yyyy)	
Date of last drawn salary (dd/mm/yyyy)	
Please furnish a copy of the Insured member's latest pay slip (If sum assured is based on salary).	
Name of authorised officer	Contact number
Signature	Date (dd/mm/yyyy)
Company Stamp	