

Happy Tails Pet insurance claim form

Important notice

- If we accept this form, it does not mean we are taking legal responsibility for your claim.
- If we ask for any documents as proof or a report, you will have to pay the costs involved in providing them.
- To avoid delay in processing your claim, please send your completed form, together with the supporting documents, within 30 days from the date of the event.
- Please do not leave any answer blank. Write 'none' or 'NA' where relevant.

Policy number:

Claim number:
(For official use)

You may email the completed claim form and supporting documents to plineclaims@income.com.sg. Please keep the original copy of the supporting documents for 6 months as we may request for them on case by case basis prior to settlement of the claim.

Personal details of policyholder

Name (as shown in NRIC, FIN or Passport)	Sex ☐ Male ☐ Female	NRIC, FIN or Passport number	Date of birth(dd/mm/yyyy)
Home address		Occupation	Nationality
Contact number (Office)	(Handphone)	Email	

Details of insured Pet

Name of Pet	Gender ☐ Male ☐ Female	Microchip number	Date of birth(dd/mm/yyyy)
Type of Pet	Breed type	Reside same premises as policyholder ☐ Yes ☐ No	

Payee's details

We will ONLY make payment via direct transfer to Policyholder's bank account. Please indicate the bank details below clearly for us to process the payment and to avoid any delay to the claim settlement.

Please select the mode of payment below:

☐ Direct Transfer to Bank (Please provide supporting documents such as bank statement for verification of payee details.)

Full name (as shown in the bank account)	NRIC, FIN or passport number (as shown in the bank account)	Nationality
Name of bank	Bank account number	

☐ For Payment by PayNow (registered with NRIC no only)

Injury or sickness claim details (please answer all questions)

Details of injury or sickness

Is the condition or disability suffered due to: ☐ Accident ☐ Sickness

1. If the condition or disability is due to sickness, please provide:

- the date the symptoms started (dd/mm/yyyy): _____
- the date of first treatment (dd/mm/yyyy): _____
- a detailed description of all symptoms and the nature of the medical condition or disability:

2. Has the sickness been treated previously? If Yes, please give details.

☐ Yes ☐ No

- the date of first treatment (dd/mm/yyyy): _____
- name and address of the Veterinarian:

3. Is the sickness due to breeding, spaying or neutering? If Yes, please specific condition:

☐ Yes ☐ No

4. If the condition or disability is due to accident, please provide: a. the date of the accident (dd/mm/yyyy): _____ b. the time of the accident: _____ c. where this happened: _____ d. a detailed description of the accident/nature and extent of injury sustained: _____
5. Has your Pet previously suffered from an injury to the same part? ☐ Yes ☐ No
6. Are there any more medical bills to be submitted? ☐ Yes ☐ No

Final expenses claim
1. Cause of death
2. Reason for Euthanasia (if applicable)

Third party liability claim
1. When were you first notified of the incident?
2. Where did the incident happen?
3. If anyone has been injured, please furnish: a. Name, NRIC number and contact details (contact number, email and home address) of injured person: _____ b. Details of nature of injury/extent of damage: _____
4. Has any intimation of the claim been made against you? If so, by whom?
Note: No payment, offer or promise of any payment or admission of liability should be made. All letters from third parties should be forwarded to us immediately upon receipt.

Other insurance coverage (Please answer all questions)
1. Is the Pet presently also insured for Pet insurance under another insurance company? ☐ Yes ☐ No If Yes, please state name of insurance company and policy number: _____
2. Is the Pet claiming from another insurance company/other sources? ☐ Yes ☐ No If Yes, please provide a copy of their settlement details:

Supporting documents

The below documents which have been **marked** will be enclosed with the claim form.

- ☐ Original medical bills/receipts
- ☐ Medical report - (Attending veterinarian to complete the attached medical report form)
- ☐ Inpatient discharge summary
- ☐ Completed clinical examination form by veterinarian, if this is the first claim submission
- ☐ Copy of death certificate
- ☐ Original receipt for euthanasia, cremation, funeral service and/or handling expenses
- ☐ Letters or writ of summons from third party with supporting documents, if any

This is not a full list and we may ask for other documents.

Personal Data Use Statement

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 (referred to in Income's Privacy Policy at <https://www.income.com.sg/privacy-policy>), Income's appointed insurance intermediaries and their respective third party service providers and representatives (collectively "Income Parties") to collect, use, and disclose any personal data in this form or obtained from other sources, including existing personal data provided, any future updates and subsequent information on my/our health or financial situation (collectively "personal data") for the purposes of processing and administering my/our insurance application or transaction, managing my/our relationship and policies with Income including providing me/us with financial advice/ financial planning services, sending me/us corporate communication and information on products and/or services related to my/our ongoing relationship with Income, conducting consumer profiling/data analytic/research, which includes data matching based on personal data collected by Income, its affiliates, business partners and/ or NTUC Enterprise group of social enterprises ("NE Group") where required for Income, its affiliates, business partners and/or NE Group, to develop, improve and/ or customise their products/ services and/ or to provide you with their respective products /services, and in the manner and for other purposes described in Income's Privacy Policy.

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

- I/we have obtained their consent for the collection, use and disclosure of their personal data; and
- I am/we are authorised to give any authorization and approval on their behalf for the purposes as set out in this Personal Data Use Statement.

Please refer to Income's Privacy Policy (<https://www.income.com.sg/privacy-policy>) for more information, including access and correction to personal data and consent withdrawal.

Declaration and authorisation

I cannot alter any of the wordings in this claim form. Any attempt to do so will have no effect.

I declare that the answers given in this form are true, correct and complete. I accept full responsibility for them, whether written by me or by anyone else on my behalf. I have not withheld any information. If it is discovered later that the insured suffers from a medical condition that is not disclosed in this form, I/we will not be entitled to rely on the defence that the information was disclosed for or in the records of other policies with Income.

I/We confirm that I/we understand and agree to the collection, use and disclosure of my/our personal data as stated in the "Personal Data Use Statement" (PDUS) above. I/We further confirm on the representation and warranty made in the PDUS.

For the purpose of administering and processing my/our claim, I authorise, consent and agree to:

- a. The medical source, insurance office, reinsurer, organisation to release to Income any medical or relevant information to do with me or the insured;
- b. Income and its relevant third parties stated in Income's Privacy Policy to collect from, use 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 assess this claim.

I confirm that all copies of the claim documents that I have submitted to Income are copies of the original documents and I agree to retain all original documents for a period of 6 months from claim submission date for Income to verify its authenticity.

I am aware that Income may reject any claim if any copy submitted is not a copy of the original document and may recover any payment made to me.

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 nor will I make any claim against any other source for the same bill(s)/invoice(s).

If I have made a claim from other source, a. I agree that I will provide a copy of any document requested by Income of the payment received by me; b. I am aware that Income will not reimburse me if I have been fully reimbursed by such source; c. I am aware that Income may only reimburse me up to the remaining balance of the unpaid bill/invoice I have been partially reimbursed by such source; d. I undertake to refund on demand any payment made by Income to me which exceeds what I have incurred in total.

I understand that I must give Income all documents, authorisations or information required by Income to assess the claim. If I fail to co-operate with Income in administering and processing the claim, I am aware that the assessment of the claim may be delayed or Income may reject the claim.

I agree that this form may be signed by electronic or digital signature, whether encrypted or not, which will be considered as an original signature for all purposes and shall have the same force and effect as an original signature. Electronic signature may include electronically scanned and transmitted versions (e.g. via pdf) of an original signature.

Name of policyholder: _____

Signature: _____

Date (dd/mm/yyyy) : _____

Claim submission instruction

You may email the completed claim form and supporting documents to plineclaims@income.com.sg. Please be reminded to keep the original copy of the supporting documents for 6 months as we may request for them on case by case basis prior to settlement of the claim.

Medical report

To be completed by Attending Veterinarian

(You will have to pay any costs involved in the veterinarian providing this report.)

Name of Pet	Microchip No.
1. What is the cause of the injury / sickness?	
2. Nature and Extent of injury / sickness	
3. Final Diagnosis	
4. Date when symptom first started	
5. Approximate date of discovery of the injury/ sickness	
6. When did the Pet first consult you for this condition?	
7. Details of presented symptoms, Nature and Date of Treatment rendered	
8. Was any invasive surgery performed under general anaesthesia? If yes, please provide details.	
9. Is the sickness due to breeding, spaying or neutering? ☐ Yes ☐ No	
10. Is the sickness preventable by vaccines and/or prophylatic medicine? ☐ Yes ☐ No	
11. Is the procedure cosmetic, preventative in nature? ☐ Yes ☐ No	
Veterinarian previously consulted by the Pet for the above condition:	
Name of Veterinarian	Date
Is the Pet still under your care for this condition? ☐ Yes ☐ No	
Signature of Veterinarian Name / Designation Date Name and Address of Clinic / Hospital	