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Attending Medical Practitioner's Statement
Cancer Drug Treatment Claim
IncomeShield Plan

Important notes

1. This form is applicable for Outpatient Cancer Drug Treatment claims where the hospital/ licensed medical centre or clinic is unable to electronically file through the system set up by MOH. This includes non-integrated IncomeShield plan, and HSA registered Drug but not found in the system set up by MOH.
2. This form is not applicable for Class F cancer drug (Refer to www.lia.org.sg for more details)
3. For integrated IncomeShield Plan policyholders, you must have a Plus/Deluxe Care/Assist/Classic Care rider.
4. Please ensure all cancer drug expenses incurred in the same month are submitted to us in the same submission. (ie. If you have multiple claims to be submitted in the same month, please collate all bills and supporting documents, and only submit them to us in one submission at the end of the month) This is to ensure we assess your claim in accordance with the policy terms and conditions.
5. This form must be duly completed to avoid delay in claim processing. Please indicate as "N.A." if not applicable.
6. Any documentary proof or report required by Income shall be furnished at the expense of the policyholder or claimant.
7. The acceptance of this form is NOT an admission of liability on the part of Income.

Please submit all claim documents via email to healthcare@income.com.sg, OR through your insurance advisor, OR at any of our branches.

Part 1 (To be completed by Insured)

Full name of insured (as shown in NRIC/Passport/Long-Term Pass/ Birth certificate)	NRIC/Passport/Long-Term Pass/ Birth certificate number	Policy number

Full name of policyholder (if different from insured)	NRIC/Passport/Long-Term Pass/Birth certificate number

Other insurances

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
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.

Payment method

Payment for claims payable under the policy will only be made via Direct Credit

Please note that you are required to submit a copy of your bank book or statement for account verification and for claims proceed to be credited into your personal bank account. (Note: You need to circle the account for crediting if your statement shows more than 1 bank account)

(Please blank out bank balances and transactions in the bank account document submitted to Income)

Declaration and authorisation

1. I confirm (a) my consent and agree to the Personal Data Use Statement (**"PDUS"**) given in the policy Application Form submitted to Income for the collection, use and disclosure of my/our personal data and, where applicable, personal data of third party, such as payor for the policy, provided by me or any other source(s) for the purposes of processing, administering the insurance application or transaction and in the manner and for the purposes described in the Income's Privacy Policy (available at http://www.income.com.sg/privacy-policy); (b) that consent (where applicable) of the third party for the collection, use and disclosure of their personal data for the aforementioned purposes has been duly obtained; and (c) on the representation and warranty made in the PDUS.

   I agree that if my policy(ies) premiums are paid by third-party payor(s), I consent to the use and disclosure of my name and relevant policy(ies) information by Income to such third-party payor(s) for the purposes of processing and/or administering premiums payments for my policy(ies).

2. For the purpose of administering and processing my claim, I authorise, consent and agree to:
   (a) The medical source, insurance office, 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, 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 agree that a copy of the authorisation in this form is valid and binding as an original copy.

3. 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.

4. 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.

5. 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).

6. 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.

7. 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 administrating and processing the claim, I am aware that the assessment of the claim may be delayed or Income may reject the claim.

8. I agree that if I or any [#]Relevant Person is found to be a [+]Prohibited Person:
   - If any policy is issued, you are entitled to end this policy, not pay any benefit or not allow any transaction, such as surrender and assignment, to be carried out under this policy. You will not refund any unutilised premium when this policy is ended.

   Your decision in every respect of the above will be final.

   I will inform you immediately if there is any change in my or any Relevant Person's identity, status or identity documents.

   [#] *Relevant Person includes insured, trustee, settlor, beneficiary, assignee, nominee, payee, mortgagee, financier of this application/policy, and in relation to an entity, its director, partner, manager, person having executive authority, authorised signatory, shareholder or beneficial owner.*

   [+] *Prohibited Person means a person or entity who is, or who is [^]Related to a person or entity:*
   - *Subject to laws, regulations or sanctions administered by any inter-government, government, regulatory or law enforcement authorities of any country, which will prohibit or restrict you from providing insurance or carrying out any transaction under this policy, or*
   - *Who is involved in any terrorist or illegal activities or placed on sanctions listing or issued with freezing order.*

   [^] *Related includes relationships such as parent, step-parent, child, step-child, adopted child, spouse, sibling, step-sibling, adopted sibling, parent-in-law, child-in-law, sibling-in-law, cousin, uncle, aunt, grandparents, niece, nephew, grandchild, employee, employer, associate, parent company, subsidiary and shareholder.*

9. 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 (eg. via PDF) of an original signature.

10. I confirm that the insured has an eligible valid pass i.e. a valid pass with a foreign identification number (FIN) recognised by the Immigration and Checkpoints Authority of Singapore (ICA). I am aware that all benefits under IncomeShield will end when the insured, who is a foreigner, no longer has an eligible valid pass, and Income will not be legally responsible for any further payment under the IncomeShield policy.

11. I agree to refund in full the monies which is paid by mistake or which I am not entitled to receive to Income immediately upon Income's request or once I found out on such mistake or wrong payment.

12. I understand and agree that once Income made payment for a claim under this form to us (including any subsequent payment arising from this claim), Income's liability for such claim will be released and discharged accordingly.

Full name and signature/thumbprint of **policyholder** (individual)	NRIC/Passport/Long-Term Pass number	Date signed (dd/mm/yyyy)
Full name and signature/thumbprint of **insured** who is 21 years old or above (if different from policyholder)	NRIC/Passport/Long-Term Pass number	Date signed (dd/mm/yyyy)

Attending Medical Practitioner's Statement
Part 2 (To be completed by Doctor)

Full name of insured (as shown in NRIC/Passport/Long-Term Pass/Birth certificate)	NRIC/Passport/Long-Term Pass/Birth certificate number
Diagnosis	**Date of Diagnosis**

[Please use Annex A of the Attending Medical Practitioner's Statement if there are more than one (1) cancer drug used]

Cancer Drug administered

1. Details of Cancer Drug

Name	
Active ingredient	
Brand	

(a) Is this cancer drug on CDL (MOH)? ☐ Yes ☐ No

If "Yes", please provide the clinical indication

Example:

CI00213	For peripheral T-cell lymphoma in adults who have received >=1 prior therapy.

Indication code	
Clinical indication	

(b) Is there also a cancer drug claim concurrently being electronically filed to IncomeShield? ☐ Yes ☐ No

If "Yes", please provide Hospital Registration No. (HRN) of the e-filed claim:

Note:

- If there is a CDL treatment (paired with a drug) combined and used at the same time with another CDL/non-CDL treatment, and this combination of drugs is not claimable under MSHL and Integrated Plans, please select the indication code CI00000 "Others" and do not select the indication code paired with the drug on the CDL.
- CDL treatments with "For Cancer Treatment" can continue to be submitted under indication code CI99999 "For Cancer Treatment".
- This note is subject to further updates from MOH.

Please complete this section if the cancer drug is not on the CDL (MOH).

2. Classification of Non-CDL

(a) What is the Non-CDL Classification of the cancer drug treatment being administered? Tick accordingly

☐ Class A	☐ Class B	☐ Class C	☐ Class D	☐ Class E	☐ Class F

Please advise the indication to provide why this cancer drug treatment falls under this classification.

(b) Has this cancer drug been approved for the patient's indication by any of the following bodies? Please tick at least one.

- ☐ HSA
- ☐ US FDA
- ☐ EMA
- ☐ TGA Australia
- ☐ Health Canada
- ☐ UK MHRA
- ☐ Others (Pls specify): _____
- ☐ None known

Attending Medical Practitioner's Statement
Part 2 (To be completed by Doctor) (continued)

(c) If 2b) is "None Known", please advise if there is any Clinical Guidelines under NCCN and ESMO for the cancer drug use. If "Yes", please provide weblink for the relevant NCCN/ESMO guideline and provide the page number corresponding to the insured's treatment OR provide a hardcopy with highlights.	☐ Yes ☐ No
(d) Was the treatment brought in via Special Access Route (SAR) under Health Science Authority of Singapore (HSA)?	☐ Yes ☐ No

3. Other information of the Cancer Drug

(a) Dosage/Quantity prescribed	
(b) Date of treatment/Start date (mm/yyyy)	
(c) What is the number of treatment(s) required in the same month?	

4. Please provide us with any other information that will be helpful in the assessment of this claim

Signature of doctor	Date (dd/mm/yyyy)
Name and qualification (printed)	Address and official stamp of clinic/hospital

Annex A - Attending Medical Practitioner's Statement
Part 2 (To be completed by Doctor)

Full name of insured (as shown in NRIC/Passport/Long-Term Pass/Birth certificate)	NRIC/Passport/Long-Term Pass/Birth certificate number

Diagnosis	Date of Diagnosis

[Please use Annex A of the Attending Medical Practitioner's Statement if there are more than one (1) cancer drug used]

Cancer Drug administered

1. Details of Cancer Drug

Name	
Active ingredient	
Brand	

(a) Is this cancer drug on CDL (MOH)? ☐ Yes ☐ No

If "Yes", please provide the clinical indication

Example:

CI00213	For peripheral T-cell lymphoma in adults who have received >=1 prior therapy.

Indication code	
Clinical indication	

(b) Is there also a cancer drug claim concurrently being electronically filed to IncomeShield? ☐ Yes ☐ No

If "Yes", please provide Hospital Registration No. (HRN) of the e-filed claim:

Note:

- If there is a CDL treatment (paired with a drug) combined and used at the same time with another CDL/non-CDL treatment, and this combination of drugs is not claimable under MSHL and Integrated Plans, please select the indication code CI00000 "Others" and do not select the indication code paired with the drug on the CDL.
- CDL treatments with "For Cancer Treatment" can continue to be submitted under indication code CI99999 "For Cancer Treatment".
- This note is subject to further updates from MOH.

Please complete this section if the cancer drug is not on the CDL (MOH).

2. Classification of Non-CDL

(a) What is the Non-CDL Classification of the cancer drug treatment being administered? Tick accordingly

☐ Class A	☐ Class B	☐ Class C	☐ Class D	☐ Class E	☐ Class F

Please advise the indication to provide why this cancer drug treatment falls under this classification.

(b) Has this cancer drug been approved for the patient's indication by any of the following bodies? Please tick at least one.

- ☐ HSA
- ☐ US FDA
- ☐ EMA
- ☐ TGA Australia
- ☐ Health Canada
- ☐ UK MHRA
- ☐ Others (Pls specify): _____
- ☐ None known

Annex A - Attending Medical Practitioner's Statement
Part 2 (To be completed by Doctor) (continued)

(c) If 2b) is "None Known", please advise if there is any Clinical Guidelines under NCCN and ESMO for the cancer drug use. If "Yes", please provide weblink for the relevant NCCN/ESMO guideline and provide the page number corresponding to the insured's treatment OR provide a hardcopy with highlights.	☐ Yes ☐ No
(d) Was the treatment brought in via Special Access Route (SAR) under Health Science Authority of Singapore (HSA)?	☐ Yes ☐ No

3. Other information of the Cancer Drug

(a) Dosage/Quantity prescribed	
(b) Date of treatment/Start date (mm/yyyy)	
(c) What is the number of treatment(s) required in the same month?	

4. Please provide us with any other information that will be helpful in the assessment of this claim

Signature of doctor	Date (dd/mm/yyyy)
Name and qualification (printed)	Address and official stamp of clinic/hospital