ntuc income

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 '√' 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) Please continue to pay the premiums to keep your policy in force.

☐ **Total & Permanent Disability Claim/Permanent Incapacity (PI) Claim (Dependants' Protection Scheme – DPS Policy)[1]**

______ Medical/Accident/Living/Permanent & Total Disability Claim Form (to be completed by Claimant)
______ Attending Physician's Statement (APS) (to be completed by attending physician & 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)

☐ **Dread Disease (Living) Claim[1]**

______ Medical/Accident/Living/Total & Permanent Disability Claim Form (to be completed by Claimant)
______ Attending Physician's Statement (APS) (to be completed by attending physician & submitted to us)
______ Medical reports/Laboratory reports/ Hospital Discharge Summary

Please also use the specific APS form if claimant is claiming under the following medical conditions: Cancer, Kidney Failure, Stroke, Heart Attack/Coronary Artery By-pass Surgery.

☐ **Medical Claim**

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

______ Medical/Accident/Living/Total & 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 reimbursement letter/discharge voucher from the Insurer/Employer (If there is previous reimbursement from another Insurer/Employer)
______ Doctor's referral letter (for i-MediCare)

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

______ Medical/Accident/Living/Total & Permanent Disability Claim Form (to be completed by Claimant)
______ A copy of the Final hospital bills & receipts
______ Medical reports, if available
______ Hospital discharge summary
______ Medical Certificates, if available

☐ **Accident Claim (Accident Benefit)**

______ Medical/Accident/Living/Total & Permanent Disability Claim Form (to be completed by Claimant)
______ Hospital discharge summary
______ Medical reports
______ Medical Certificates
______ Accident reports
______ A copy of the Final hospital bills & receipts
______ Police Report, if any

[1] *For overseas reports, they are to be translated into English, and certified as true copies by either the Notary Public, or by the relevant embassy in the country where the reports originated.*

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
NTUC INCOME Centre
Singapore 189557

[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**.

LC/CL/10/2009

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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 NTUC Income. Any documentary proof or report required by NTUC 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.

Policy No.(s)	Plan Type	Claim No.

Particulars of Insured

Name of Patient/Insured (as shown in NRIC/PP)	NRIC/Passport No.	Gender ☐ Male ☐ Female
Occupation (If unemployed, please indicate last occupation)	☐ Employed ☐ Self Employed	Date of Birth (dd/mm/yyyy)
Name of Employer	Period of Employment (dd/mm/yyyy) From ______ To ______	
Name of Policyholder (if different from Patient/Insured)	NRIC No.	Gender ☐ Male ☐ Female
Address		
Contact No. (O) (H) (Hp) (Fax)	Email	

For Accident/Disability Claims only

1. Details Of Occupation [1]	**Before Injury/Disability**	**After Injury/Disability**
a. Occupation		
b. Name of Employer		
c. Average monthly income (please furnish copy of last payroll)		
d. List exact duties performed at work (If the Insured is not working, please provide a list of daily activities before and after the disability)		

e. Date the Insured last worked (dd/mm/yyyy) : ____________________

f. Date the Insured returned to work (dd/mm/yyyy) : ____________________ OR

Date the Insured expect to return to work (dd/mm/yyyy) : ____________________

g. Is the Insured currently confined to:

☐ bed ☐ house ☐ hospital ☐ N.A.

[1] NTUC Income reserves the right to request for documentary evidence.

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NTUC Income Centre 75 Bras Basah Road Singapore 189557 | t. 63 INCOME (6346 2663) | f. 6338 1500 | csquery@income.com.sg | www.income.com.sg

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.

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) Has the Patient/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) ____________________

(ii) During this period, has the Patient/Insured returned to work to resume full or light duties? ☐ Yes ☐ No

If "Yes", please state the date the Patient/Insured returned to work (dd/mm/yyyy): ____________________

3. ☐ How was the Patient/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 Patient/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)

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 Patient/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 your 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 Patient/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 Patient/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 No.	Date of Issue	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/advice from the other insurance company or other sources.						
11. Has the Policyholder or Patient/Insured 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 state details below.						☐ Yes ☐ No

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 may be committing an offence if you claim or are reimbursed for more than the amount that you have paid, regardless of the number of medical insurance policies you may have.

Payment Method

Please tick box to indicate payment method ☐ By Cheque ☐ Credit into my personal account[2]	
Name of Bank	Branch
Account Holder's Name	Account No.

[2] If you select this option, you will need to submit a copy of your bank statement for account verification. Please note that we do not accept joint accounts for security reasons.

For Group Policyholders only

Name of Member/Employee (if different from Patient/Insured)	NRIC No.
Name of Company/Union	Date joined Company/Union (dd/mm/yyyy)
Name of Authorised Officer	Contact No.
Payment to be made to ☐ Company/Union (please complete payment mode above) ☐ Member/Employee (including payment into Medisave account) ☐ Others, please specify ______	

Declaration

1. I hereby declare that the above statements are true and complete and I have not withheld any material fact from NTUC Income.
2. I agree and authorise:
   (a) Any medical institution or medical practitioner, or insurer, or organisation or person to release to NTUC Income any information as requested by NTUC Income; and
   (b) NTUC Income to release any relevant information concerning me/my child to any medical institution or medical practitioner, or insurer or organisation or person.
   A photocopy of this form is valid as an original copy.
3. I hereby 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 of a claim under the Dependants' 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.
4. 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.

Name and Signature of Policyholder (Individual)	NRIC No.	Date (dd/mm/yyyy)
Name and Signature of Patient/Insured (If different from Policyholder and age above 21 years)	NRIC No.	Date (dd/mm/yyyy)
Name and Signature of Authorised Officer (for Group Policyholders only)	Date (dd/mm/yyyy)	Company/Union Stamp

For Official Use

Claim No.	Next Premium Due Date	Hospital/Accident benefit (per day/week) $	
No. of days hospitalised	Amount ($)	Signature of Officer(s)	Remarks
No. of days of medical leave	Amount ($)	Date (dd/mm/yyyy)	
Please pay	Total ($)		

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ATTENDING PHYSICIAN'S STATEMENT

Part 1 (To be completed by the Insured)

Policy No.	Plan Type	Claim No.
Name of Insured (as shown in NRIC)		NRIC No.
Address of Insured		
Name of Next-of-Kin (if Insured is below age 21 or deceased)	Relationship to Insured	NRIC No.
Address of Next-of-Kin		

Authorisation

I agree and authorise:

a) Any medical institution or medical practitioner, or insurer, or organisation or person to release to NTUC Income any information as requested by NTUC Income; and

b) NTUC Income to release any relevant information concerning me/my child to any medical institution or medical practitioner, or insurer, or organisation or person.

A photocopy of this form is valid as an original copy.

Signature/Thumbprint of Insured/Next-of-Kin[1]

Date (dd/mm/yyyy)

Part 2 (To be completed by the Doctor)

Name of Insured (as shown in NRIC)	NRIC No.

Height of Insured ____________ m

Weight of Insured ____________ kg

The above readings were taken on this date (dd/mm/yyyy) ______ /______ /______

1. Are you the Insured's usual doctor? ☐ Yes ☐ No
   Over what period do your records extend?
   Start Date (dd/mm/yyyy) ______ /______ /______
   End Date (dd/mm/yyyy) ______ /______ /______

2. What is the diagnosis for the Insured's present illness/injury?

   a) What is the exact date of diagnosis?
   (dd/mm/yyyy) ______ /______ /______

   b) Was the Insured informed of the diagnosis? ☐ Yes ☐ No
   If "Yes", when was he first informed? (dd/mm/yyyy) ______ /______ /______

   c) Is the Insured's present illness or condition caused by any other underlying disorders? ☐ Yes ☐ No
   If "Yes", please give details.

[1] Please delete accordingly

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3. a) Was the condition caused by an accident? ☐ Yes ☐ No
If "Yes", please state:
Accident Date (dd/mm/yyyy) ______ /______ /______ Accident Time ______________

b) Describe the accident.

c) Was the accident reported to the police? ☐ Yes ☐ No
If you happen to possess a copy of the police report, please enclose it.

d) Was the Insured under the influence of alcohol/drugs at the time of accident? ☐ Yes ☐ No
If "Yes", please state the blood alcohol content/drug type and quantity consumed.

e) Is the Insured's condition self-inflicted or as a result of suicide? ☐ Yes ☐ No
If "Yes", please provide details.

4. Please provide details of the symptoms presented when you first saw the Insured.

Symptoms presented	Duration of symptoms	Date symptoms first occurred (dd/mm/yyyy)

5. Was the Insured referred to you by another doctor? ☐ Yes ☐ No
If "Yes", please provide details.

Name of Referring Doctor	Name and Address of Clinic/Hospital	Date Insured consulted referring doctor (dd/mm/yyyy)	Reason(s) for the Referral

6. Did the Insured see any other doctor(s) besides those indicated above? ☐ Yes ☐ No
If "Yes", please provide details.

Name of Doctor	Name and Address of Clinic/Hospital	Date Insured consulted doctor (dd/mm/yyyy)	Diagnosis Made

7. What were the investigations done to confirm the diagnosis?

Please also enclose copies of all reports used in the management of the Insured's condition(s), e.g. biopsy reports, cytology and histopathology reports, x-rays, CT and MRI scans, other imaging studies, laboratory reports, surgical reports, rehabilitation and occupational therapy report, and other relevant reports.

8. a) Please provide details of treatment that has been provided (e.g. surgery, chemotherapy, radiotherapy, physiotherapy etc.).

Type of Treatment	Date of Treatment (dd/mm/yyyy)	Duration of Treatment	Response to Treatment

b) Are there plans for other forms of treatment? ☐ Yes ☐ No
If "Yes", please provide full details.

Type of Treatment	Expected Date of Treatment (dd/mm/yyyy)

9. What is the prognosis of the Insured's condition? ☐ Improve ☐ Deteriorate ☐ Remain unchanged

a) Please describe the nature and severity of the Insured's condition.

b) Is full recovery expected? ☐ Yes ☐ No
If "Yes", please state approximate date (dd/mm/yyyy) ______ /______ /______
If "No", please state the extent of recovery and approximate date (dd/mm/yyyy) ______ /______ /______

c) At your last assessment, does the Insured have any deficits pertaining to his general motor functions? ☐ Yes ☐ No
If "Yes", please provide details in (i) to (iv).
Date of last assessment (dd/mm/yyyy) ______ /______ /______

i. Range and strength (please indicate power grading of limbs)

ii. Gait and balance

iii. Coordination

iv. Movement

d) Are there any neurological deficits pertaining to the Insured's sensory functions, or other aspects like hearing, smell, visual? ☐ Yes ☐ No
If "Yes", please provide details.

10. Is the Insured able to perform all the 6 Activities of Daily Living (feeding, mobility, transferring, washing/bathing, dressing and toileting/continence) independently? ☐ Yes ☐ No

a) If "No", what are the activities the Insured cannot perform independently? Does the Insured require minimal or maximum assistance in these activities?

b) Is the Insured confined to a home/hospital/or other institution which provides continuous care and medical attention? ☐ Yes ☐ No
If "Yes", please provide name and address of this institution, and period(s) of confinement (dd/mm/yyyy).

11. What was the Insured's occupation before his disability?

a) What was the nature of his duties?

b) Does the Insured's disability prevent him from performing the above listed duties? ☐ Yes ☐ No
If "Yes", please state why.

12. a) Has the Insured returned to his usual occupation? ☐ Yes ☐ No

b) If "No", would the Insured be able to return to his usual occupation at a later date? ☐ Yes ☐ No

☐ Not able to determine presently (Go straight to Question 15)

☐ Yes - Expected date of return to his usual occupation is (dd/mm/yyyy) ______ /______ /______

☐ No - Not possible to return to usual occupation even at a later date

13. If the Insured cannot return to his usual occupation even at a later date because of his condition, is there any other suitable occupation(s) that he can consider **in the future**?

☐ Yes Examples of such occupation(s) are: ______________________
Expected date where his condition allows him to engage in these occupation(s) is:
(dd/mm/yyyy) ______ /______ /______

☐ No The Insured's condition makes it **highly unlikely** for him to take part in **any work, occupation or business for remuneration or profit permanently.**

14. If you have answered "No" to Question 13, please state the date when the Insured is considered not able to take part in **any work, occupation or business for remuneration or profit permanently.**

(dd/mm/yyyy) ______ /______ /______

15. If the extent of the Insured's disability cannot be determined at this moment, when would be an appropriate date to assess it?

(dd/mm/yyyy) ______ /______ /______

16. a) Please describe the Insured's mental and cognitive abilities.

b) Is the Insured mentally incapacitated in accordance to the Mental Incapacity Act? ☐ Yes ☐ No

c) If "Yes" to Question 16b above, please state the date when the mental incapacity started.

(dd/mm/yyyy) ______ /______ /______

17. Is the Insured suffering or has suffered from any other disease or ailment? ☐ Yes ☐ No
If "Yes", please provide full details.

Name of Doctor	Name and Address of Clinic/Hospital	Date Insured consulted doctor (dd/mm/yyyy)	Diagnosis Made

18. Is the Insured terminally ill, i.e. death is expected within 12 months?	☐ Yes ☐ No
19. 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 & Official Stamp of Clinic/Hospital