

CLAIM FORM FOR CO-PAY ASSIST PLAN

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. To avoid delay in processing your claim, please submit the duly completed claim form together with the supporting documents within 90 days from date of occurrence.

In order for us to process your claim, please:

1. submit original/certified true copies of final medical bill(s) and receipt(s);
2. furnish the Reimbursement Letter from your employer if the bill does not indicate the employer's liability;
3. settle your bills before making a claim for reimbursement; and
4. do not leave any blank space. Please indicate "NA" if not applicable.

Name of Proposer (as shown in NRIC/FIN/Passport)		Policy No.	
Residential Address		NRIC/FIN/Passport No.	
Contact No.			
(H)		(Hp)	
(O)		(Hp)	
Name of Employer	Occupation	Department	Division (please circle the appropriate) I / II / III / IV
Name of Insured (if different from Proposer)		NRIC/FIN/Passport/BC No.	Policy No.
Name of Hospital		Date of admission	Date of discharge
Nature of illness or injury		Date of first consultation with doctor for this condition/injury	

Other Insurance

- 1) Are you covered for medical expenses by any other insurance company(ies), your employer or any other parties? If "Yes", please state details below.
- 2) Have you submitted a claim for the bill(s) concerned to any insurance company(ies), your employer or any other parties yet? If "Yes", please state details below.

Note: It is important to tell 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 reimburse for more than the amount that you have paid, regardless of the number of medical insurance policies you may have.

I hereby warrant that the above statements are true and complete and that I have not withheld any material fact from NTUC Income. I consent to NTUC Income obtaining medical information from any doctor I/my child have/has consulted and I authorise the giving of such information. I agree that a photocopy of this form shall be valid as the original.

Signature of Proposer

Signature of Insured (if above 21)

Date (dd/mm/yyyy)

For Official Use

Ward under Co-Pay Assist Plan _____	Policyholder \$ _____	Checked by _____
Employer's liability \$ _____	Medisave \$ _____	Date (dd/mm/yyyy) _____
Eligible bill \$ _____	MediShield \$ _____	Approved by _____
Co-payment Percentage _____	Others \$ _____	Date (dd/mm/yyyy) _____
Amount payable \$ _____		
Hospital bill \$ _____		

GH/CL/12/2010

APPLICATION FOR CLINICAL ABSTRACT

To: The Doctor-in-Charge

Dear Sir/Madam

Please furnish NTUC Income Insurance Cooperative Limited, 75 Bras Basah Road, NTUC Income Centre, Singapore 189557 with a medical report on:

(Name & NRIC/BC No.)

This information is desired for insurance purposes. Upon receipt of this application from NTUC Income, you may furnish a detailed medical report for use in connection with litigation or for other legitimate purposes.

I agree that a photocopy of this form shall be as valid as the original.

Yours faithfully

Signature of Insured
(If Insured is above 21)

Signature of Next-of-Kin
(If Insured is below 21 or deceased)

Name

Name

Address

Address

NRIC No.

NRIC No.

Date (dd/mm/yyyy)

Relationship to Insured

Date (dd/mm/yyyy)

GH/CL/12/2010