

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) Claim¹

- _____ 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
- _____ Hospital discharge summary
- _____ Medical reports, if available
- _____ 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 Certificates
- _____ A copy of the Final hospital bills & receipts
- _____ Medical reports
- _____ Accident reports
- _____ 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 branches², 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.

**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.
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Particulars of Insured

Name of Patient/Insured (as shown in NRIC/PP)	NRIC/Passport No.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Occupation (If unemployed, please indicate last occupation)	<input type="checkbox"/> Employed <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> bed <input type="checkbox"/> house <input type="checkbox"/> hospital <input type="checkbox"/> N.A.		

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

LI/GH/CL/10/2009

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.						<input type="checkbox"/> Yes <input type="checkbox"/> 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.						<input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> By Cheque <input type="checkbox"/> 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 <input type="checkbox"/> Company/Union (please complete payment mode above) <input type="checkbox"/> Member/Employee (including payment into Medisave account)	
<input type="checkbox"/> 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 (\$)		
Please pay	Total (\$)	Date (dd/mm/yyyy)	