

## SilverCare, Hospital Care, Specialcare, MerdekaCare insurance claim form

### Important notice

- If we accept this form, this 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 it.
- To avoid delay in processing your claim, please send us your filled-in form together with the supporting documents within 30 days from date of the event.
- Please do not leave any answer blank. Write 'none' or 'NA' where relevant.

**Policy number:**

**Claim number:**  
(For official use)

This claim is based on the policy below. Please tick accordingly.

SilverCare  Hospital Care  SpecialCare (Autism/down syndrome)  MerdekaCare

### Personal details of policyholder

Name of policyholder (as shown in NRIC)	NRIC number	Date of birth (dd/mm/yyyy)
Home address	Occupation	
Contact number. (Office) (Home) (Handphone)	Email	

Note: For death claim, to fill in the details of the person filing the claim under the policyholder.

### Personal details of insured (Do not fill this in if it is the same as above)

Full name (as shown in NRIC)	NRIC number	Date of birth (dd/mm/yyyy)
Home address	Occupation	
Contact number. (Office) (Home) (Handphone)	Email	

### Payee's details

Payment will be made via direct transfer to policyholder's bank account. Please indicate the bank details clearly for us to process the payment.

Full name (as shown in the bank account)	Name of Bank	Bank Account Number
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### Details of incident, injury or illness

Date of incident (dd/mm/yyyy)	Time of incident <input type="checkbox"/> am <input type="checkbox"/> pm	Place of incident
Say what happened		
Nature and extent of injury or illness sustained		
1. Has the insured person previously suffered a similar injury or illness? If Yes, please give details.		<input type="checkbox"/> Yes <input type="checkbox"/> No
2. How long was the hospital stay?		
3. Please advise if your hospital or medical leave is finalised and completed? If Yes, please state the date the insured return to work (dd/mm/yyyy): _____ If No, please state when the hospital or medical leave is expected to be completed (dd/mm/yyyy): _____		<input type="checkbox"/> Yes <input type="checkbox"/> No

### Other insurance cover (Please answer all questions.)

1. Does the insured have other insurance cover to refund medical expenses?  
If Yes, please give the name of the insurer and the policy number.  Yes  No
2. Does the insured's employer have other insurance cover (for example, Workmen's Compensation) for medical expenses?  
If Yes, please give the name of the insurer and the policy number.  Yes  No
3. Has a similar claim for medical expenses for this Injury or illness been made from the above insurer in 1 and 2?  
If Yes, when was the claim made?  Yes  No

### Supporting documents

- (A) If you are claiming for **Daily Hospital Income** or **ICU triple cover** [ for hospital care only ], please send us the following.
1. A copy of the final hospital bill
  2. An inpatient discharge summary (if you have to stay in hospital)
  3. A filled-in medical report (see 4<sup>th</sup> page of the claim form)
- (B) If you are claiming for **medical expenses** or **ambulance fee**, please send us the following.
1. Original final hospital and medical bills as well as receipts for all the expenses
  2. Inpatient discharge summary (if you have to stay in hospital)
  3. A filled-in medical report (see 4<sup>th</sup> page of the claim form)
  4. A copy of the reimbursement letter from another insurer or employer (if this applies)
- (C) If you are claiming for **permanent disability, mobility aids, home modification, caregiver training** [ for SilverCare, SpecialCare (Autism) and MerdekaCare only ], **senior day care, home care, nursing service expenses or home-cleaning expenses** [ for SilverCare and MerdekaCare only ], please send us the following.
1. Original bills and receipts for all the expenses
  2. Inpatient discharge summary (if you have to stay in hospital)
  3. A filled-in medical report (see 4<sup>th</sup> page of the claim form)
  4. Prescription from your doctor for a mobility aid (if this applies)
  5. Referral letter by your doctor for admission to nursing home (if this applies)
- (D) If you are claiming for **personal liability** [ for SpecialCare(Autism) only ], please send us the following.
1. Photographs of damage caused
  2. Original purchase invoice or receipts of the damaged items
  3. Letter or writ of summons from someone else
- (E) If you are making a claim for **death** [ for SilverCare, SpecialCare (Autism) and MerdekaCare only ], please send us the following.
1. A copy of the death certificate
  2. The autopsy report, toxicological report and coroner's findings
  3. Proof of your relationship with the person who died

Policyholder or person claiming	Documents needed
Husband or wife	Marriage certificate
Parent	Birth certificate of person who has died
Child	Birth certificate of policyholder or person claiming
Brother or sister	Birth certificate of person who has died and policyholder or person claiming

4. Last will of the person who died (if they left a will) or letter of administration (if there is no will)
5. Original bills and receipts for final expenses (if this applies)

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

### Personal data collection statement

Income recognises its obligations under the Personal Data Protection Act 2012 (PDPA) which include the collection, use and disclosure of personal data for the purpose for which an individual has given consent to.

The personal data collected by Income includes all personal data provided in this form, or in any document provided, or to be provided to us by you or your insured persons or from other sources, for the purpose of this insurance transaction. It includes all personal data for us to evaluate or administer this transaction. For example, if you are submitting a claim for an insurance policy, in addition to the personal data provided in the claim form, the personal data will also include any subsequent information we collect on health or any information that is necessary for us to decide whether to pay the claim, such as test results, medical examination results, and health records from medical practitioners.

Before your insured persons' personal data is collected by us, we rely on you to notify, inform and make them aware of the following:

- (a) that you will or may provide their personal data to us, or their personal data may be provided from other sources to us;
- (b) the third parties to whom the personal data may be provided by us;
- (c) the purposes we and the third parties will use it for; and
- (d) how your insured persons can access their personal data.

We also rely on you to obtain their consent on all the above matters and will assume that their consent has been obtained before their personal data is collected by us. If you have not done or will not do any of the above matter, you must alert us before any relevant personal data is collected by us.

You may not alter any of the wording in this 'Personal data collection statement'. Any attempt to do so will be of no effect.

### 1. Purpose of collection

We may collect and use the personal data to:

- (a) carry out identity checks;
- (b) carry out membership or information checks;
- (c) communicate on purposes relating to an application or policy;
- (d) decide whether to insure or continue to insure you and your insured persons;
- (e) provide ongoing services and respond to your inquiries or instructions;
- (f) make or obtain payments;
- (g) investigate and settle claims;
- (h) recover any debt owed to us;
- (i) detect and prevent fraud, unlawful or improper activities;
- (j) conduct research and statistical analysis;
- (k) coach employees and monitor for quality assurance;
- (l) reinsure risks and for reinsurance administration;
- (m) comply with all applicable laws, including reporting to regulatory and industry entities; and

### 2. Disclosure of personal data

We may disclose personal data belonging to you or your insured persons for the purposes set out in Section 1 to these parties:

- (a) your insurance agents, insurance broker, association, employer or group policyholder;
- (b) medical professionals and institutions;
- (c) insurers and reinsurers;
- (d) local or overseas service providers to provide us with services such as printing, mail distribution, data storage, data entry, marketing and research, disaster recovery or emergency assistance services;
- (e) debt collection agencies;
- (f) dispute resolution parties;
- (g) parties that assist us to investigate, administer and adjudicate claims;
- (h) financial institutions;
- (i) credit reference agencies;
- (j) industry associations; and
- (k) regulators, law enforcement and government agencies.

### 3. Consequence of withdrawing consent to the collection, use and disclosure of personal data

You may refuse or withdraw your consent for us to collect, use or disclose your personal data and your insured persons' personal data by giving us reasonable notice so long as there are no legal or contractual restrictions preventing you from doing so. For example, you may withdraw your consent for your personal data to be used for marketing purposes, and this withdrawal will not affect our ability to provide you with the products and services that you asked for or have with us. But if you withdraw your consent for us to use your personal data for your insurance matters, this will affect our ability to provide you with the products and services that you asked for or have with us, including preventing us from keeping your insurance cover in force or properly assessing and processing your claim. Withdrawing such consent will require you to surrender or terminate all your policies with us.

### 4. Access and correction rights

You can request access to any personal data of yours that we have, and request to know how it is being used and disclosed for the last 12 months to the extent your right is allowed by law. If we allow you access, we may charge you a reasonable fee. You also have the right to request correction of your personal data.

You may make your request to access or correct your personal data by writing to:

The Data Protection Officer, Income Centre, 75 Bras Basah Road, Singapore 189557. Alternatively, you can email to: [DPO@income.com.sg](mailto:DPO@income.com.sg). For any request to withdraw your consent, please contact Income Contact Centre at 6788 1777 or email to [consentwithdrawal@income.com.sg](mailto:consentwithdrawal@income.com.sg).

## Declaration and authorisation

I certify that the information in this form is true and complete and I have not withheld any material information.

I confirm that I understand and agree to the 'Personal data collection statement'.

For the purposes of policy administration including processing and investigating this claim, and deciding whether Income is to insure or continue to insure me for my insurance applications or policies,

- a. I authorize any person or organization who has relevant information pertaining to this claim, including any medical practitioner, health care provider or institution, insurance company, and investigative agencies, to release and exchange such information (including personal health information) requested by Income and/or its claims service providers.
- b. I authorize Income and its claims service providers to collect, use, disclose and to exchange with the persons or organizations listed above any information (including personal health information).
- c. I am authorized to disclose information (including personal health information) about the insured person if this claim is made on behalf of them.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Name of policyholder: \_\_\_\_\_

Name of insured: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Date (dd/mm/yyyy) : \_\_\_\_\_

Date (dd/mm/yyyy) : \_\_\_\_\_

**Before sending this to us, please make sure you have filled in all the relevant sections related to your claim in full and you have attached the documents we have asked for together with the form. We will process your claim when we receive the full supporting documents. Please send the claim documents to any of our branches. Or, you can give them to your insurance agent, or post them to : Property & Casualty Claims, Income, PO Box 0132, Singapore 911802.**

# Medical report

**The doctor must fill this in.**

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

Name of Patient	NRIC number		
1. Final diagnosis			
2. Date of diagnosis (dd/mm/yyyy)			
3. Nature of injury or condition and the extent of the injury			
4. Was the condition caused by an accident? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> a) If Yes, please give: the date of the accident (dd/mm/yyyy): _____ Time of accident: _____ AM/ PM Describe the accident _____ b) If No, please state the cause of condition: _____			
5. Was any surgery carried out for this condition? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If Yes, please provide nature of treatment/name(s) of surgical procedure(s), surgical code & table.			
6. Was the insured under the influence of alcohol or drugs at the time of the accident? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If Yes, please state the blood alcohol content or type of drug and the quantity consumed.			
7. Is the Insured's condition self-inflicted or as a result of attempted suicide? If Yes, please provide details. <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
8. Is the injury likely to cause loss of use of the injured part? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
9. Is the loss likely to be permanent? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If Yes, to what extent (as a percentage of disability) and the date (dd/mm/yyyy) the loss is confirmed to be permanent.			
<b>For illness (if this applies)</b>			
1. Date of symptom first started (dd/mm/yyyy)	2. When did the patient first consult you about this condition?		
3. Details of present symptoms, nature and date of treatment given			
4. What were the underlying conditions? Please provide date of diagnosis			
5. Doctors previously consulted by the patient for the above condition:			
Name of doctor	Date of consultation	Name of clinic or hospital	Address
6. Has the patient fully recovered from the condition? If No, what follow up treatment are needed?			
_____ Signature of doctor		_____ Date (dd/mm/yyyy)	
_____ Name and position		_____ Name and address of clinic or hospital	