NTUC Income Insurance Co-operative Limited
Income Centre 75 Bras Basah Road Singapore 189557
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an NTUC Social Enterprise

Claim form for Co-Pay Assist plan

Important notes

1. The acceptance of this form is NOT an admission of liability on the part of Income. Any documentary proof or medical report must be given at the expense of the policyholder or patient.

2. Please submit the following documents within 30 days of the patient's discharge from hospital:
   (a) Please complete all items in this claim form and indicate as "N.A" if not applicable.
   (b) Copy of the inpatient discharge summary/ambulatory form/hospital pre admission form.
   (c) Original/certified true copies of the final hospital bill(s) and receipt(s).
   (d) Please settle your bills before making a claim for reimbursement. If the bill does not indicate the amount that your employer/Pension Department has paid, please provide us with a copy of the reimbursement letter from your employer/Pension Department.

   Please ensure that all required documents are completed and submitted together with this claim form to avoid any delay in processing your claim.

3. When we pay an eligible claim, precedence shall be given in the following order:
   - Policyholder if he has settled the eligible medical bills by cash
   - Medisave account as indicated in the tax invoices or bills
   - Patient's Medisave-Approved Integrated Shield Plan or CPF MediShield Life (if applicable) in accordance with the CPF Act.

Particulars of policyholder

Name of policyholder (as shown in NRIC, FIN or Passport)	NRIC, FIN or Passport number	Nationality	Policy number

Address	Contact details (Mobile) (Home or office) (Email address)

If your contact particulars (i.e. address, contact number and email) indicated in this form are different from your existing records with us, we will not update all your existing policies with the new contact particulars.

Name of employer	Occupation	Department or division

Particulars of patient (if patient is different from policyholder)

Name of patient (as shown in NRIC, Fin, Passport or BC)	NRIC, Fin, Passport or BC number	Nationality	Policy number

Medical condition

a. Illness or injury	b. Describe symptoms	c. Date the symptoms started (dd/mm/yyyy)

d. Name of hospital	e. Surgical procedure (if any)	f. Period of hospitalisation or surgery (dd/mm/yyyy)

Other information

Have you claimed or do you intend to claim from any insurer, other employer or any other parties for reimbursement of your medical bills? If 'Yes', please state the party that you are claiming from and submit a copy of the settlement letter or payment voucher from the other party. Note: It is important that you inform us if you are claiming from another insurer, other employer or any other parties for the same bill. You can only be reimbursed once for the amount that you have incurred regardless of the number of medical insurance policies you may have. We reserve the right to recover if there is any excess amount paid to you.	☐ Yes ☐ No

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.

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 this transaction;
(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; and
(m) comply with all applicable laws, including reporting to regulatory and industry entities.

2. Disclosure of personal data

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

(a) your financial advisers, 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.

For any request to withdraw your consent, please contact Income Contact Centre at 6788 1777 or email to 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 authorise any person or organisation 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 authorise Income and its claims service providers to collect, use, disclose and to exchange with the persons or organisations listed above any information (including personal health information).

c. I am authorised 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 authorisation shall be as valid as the original.

Name of policyholder	Signature of policyholder	Date (dd/mm/yyyy)
Name of patient (if different from the policyholder)	Signature of patient (To be signed by patient's parent or legal guardian if patient is below 21 years old)	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	$				