income made different

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

Personal accident/infectious diseases insurance claim form

Important notice

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

Policy number:	
Claim number: (For official use)	

Personal details of policyholder

Name (as shown in NRIC, FIN or Passport)	Sex ☐ Male ☐ Female	NRIC, FIN or Passport number	Date of birth(dd/mm/yyyy)
Address			Occupation/Business
Contact number (Office) (Home) (Handphone)			Email
Is your Company/Business GST registered?		GST registered number	

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

Personal details of insured

Name (as shown in NRIC, FIN or Passport)	Sex ☐ Male ☐ Female	NRIC, FIN or Passport number	Date of birth(dd/mm/yyyy)
Relationship to policyholder or person claiming ☐ (please give details) _____ ☐ Employee			Occupation

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

Medical or accident claim details (please answer all questions.)

1 Details of injury or infectious disease

Is the condition or disability suffered due to: ☐ Accident ☐ Infectious disease

a If the condition or disability is due to infectious disease, please provide:

(i) the diagnosis _____

(ii) the date your symptoms started (dd/mm/yyyy): _____ /_____ / _____

(iii) a detailed description of all symptoms and the nature of the medical condition or disability.

_____

b If the disability is due to accident, please provide:

(i) the date of the accident (dd/mm/yyyy): _____ /_____ / _____ (ii) the time of the accident _____

(iii) where this happened _____

(iv) a detailed description of the nature of your injuries or disability suffered

_____

(v) a detailed description of the accident (Please enclose a copy of the police report, if any.)

_____

c (i) Has the insured been given hospital or medical leave? If 'Yes', please give the start and end date of the hospital or medical leave. ☐ Yes ☐ No

Start date (dd/mm/yyyy) _____ End date (dd/mm/yyyy) _____

(ii) Please advise if your hospital or medical leave is finalised and completed? ☐ Yes ☐ No

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): _____

2 How were you admitted to the hospital?

☐ Referral by a general practitioner, specialist or other hospital (please delete)
Please give the name and address of the referring doctor or hospital.

_____

☐ A & E department

3 Please provide the name, contact number and address of the doctor who is treating you for your current condition or injury.

4 Was any surgery carried out for this condition? If Yes, please provide details below. ☐ Yes ☐ No

Surgical operation or procedure	**Date of operation or procedure** (dd/mm/yyyy)	**Surgical code or table** (please ask to your doctor)

5 Has the insured person previously suffered a similar injury or illness? ☐ Yes ☐ No

If Yes, please give details.

6 Has treatment been completed? If no, please say when the treatment is expected to be completed. ☐ Yes ☐ No

7 ☐ Others sections
For any other claim which does not fall within the sections shown above, please provide details of the claim. If there is not enough space below, please attach another page.

Other insurance coverage (Please answer all questions.)

1 Does the insured have other insurance cover for refunding medical expenses? ☐ Yes ☐ No
If Yes, please give the name of the insurer and list the policy plan and sum assured:

2 Does the insured's employer have other insurance cover (for example, workmen's compensation) for medical expenses? ☐ Yes ☐ No
If Yes, please give the name of the insurer and list the policy plan and sum assured:

3 Has a similar claim for medical expenses for this incident been made from the insurers named above in 1 and 2? ☐ Yes ☐ No

Supporting documents

The below documents which have been **marked** will be enclosed with the claim form.

☐ **Death Claim:**

☐ 1 For death in Singapore – copy of death certificate

For death outside Singapore –

(a) certified true copy of death certificate by your lawyer or any notary public

(b) Letter from Immigration and Checkpoint Authority (ICA) - this letter is issued by ICA for Singaporeans or permanent residents (PR) who died overseas. It confirms they saw the Singapore IC, passport and overseas death certificate

(c) Repatriation report (if the body was sent home to Singapore for cremation or burial)

☐ 2 Autopsy report, toxicological report or coroner's findings

☐ 3 Proof of policyholder's or claimant's relationship to 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 certificates of person who died and policyholder or person claiming

☐ 4 Newspaper clipping and police or accident report (if death was due to accidental or violent causes)

☐ 5 Last will of deceased (if they had left a will) or letter of administration (if there is no will)

☐ 6 Estate duty certificate

☐ **Permanent disability claim:**

☐ 1 Medical report - (Attending doctor to complete the attached medical report form)

☐ 2 Medical report stating clearly the start, cause, extent of permanent disability and nature of injury or illness

☐ 3 Newspaper clipping and police or accident report

(if total and permanent disability or permanent incapacity was due to accidental or violent causes)

☐ **Medical expenses claim:**

☐ 1 Medical report – (Attending doctor to complete the attached medical report form)

☐ 2 Medical reports or laboratory reports or inpatient discharge summary

(stating clearly the start date, cause, extent of permanent disability (if this applies) and nature of injury or illness)

☐ 3 For a stay in hospital (if this applies and the claim is eligible) - Original final hospital bill and receipt of payment

☐ 4 For outpatient treatment (if this applies and the claim is eligible) – Original itemised medical bill and receipt of payment

☐ 5 Newspaper clipping and police or accident report

☐ 6 If items 3 and 4 have been given to another insurer or employer, please provide:

☐ (a) a certified true copy of the bills by the insurer or employer;

☐ (b) a reimbursement letter or payslip reflecting the co-payment by the insured or the employer; or

☐ (c) a discharge voucher or settlement advice by the insurer

☐ **Weekly cash claim**

☐ 1 Medical report - (Attending doctor to complete the attached medical report form)

☐ 2 Medical reports or laboratory reports or inpatient summary

(stating clearly the start date, cause, extent of permanent disability (if this applies) and nature of injury or illness)

☐ 3 Newspaper clipping and police or accident report

☐ 4 Medical leave certificate

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. 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 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? ☐ Yes ☐ No

   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? ☐ Yes ☐ No
   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? ☐ Yes ☐ No
   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. ☐ Yes ☐ No

8. Is the injury likely to cause loss of use of the injured part? ☐ Yes ☐ No

9. Is the loss likely to be permanent? ☐ Yes ☐ No
   If Yes, to what extent (as a percentage of disability) and the date (dd/mm/yyyy) the loss is confirmed to be permanent.

For illness (if this applies)

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