income made different

NTUC Income Insurance Co-operative Limited
Income Centre 75 Bras Basah Road Singapore 189557
Website: www.income.com.sg · Fax: 6338 1500
an NTUC Social Enterprise

Product Type
☐ Affinity ☐ ElderShield
☐ DPS ☐ IncomeShield
☐ Employee Benefit ☐ Life Insurance

Injury questionnaire

Please complete ONE questionnaire for each injury declared.

If you have any questions on Life Insurance, please contact us at 6788 1122 or csquery@income.com.sg
For questions on other product type, you may contact us at 6332 1133 or healthcare@income.com.sg

Details of insured

Name (as shown in NRIC or FIN)	NRIC number or FIN	Proposal number(s)

Questions for insured

1 Description

a) What injuries did you sustain, on which parts of body and how did you sustain the injuries?

Diagnosis or description of injuries sustained	
Which part(s) of the body (left or right or both) was affected?	
Date (dd/mm/yyyy) and nature of accident	

b) Was there head injury?
☐ Yes (please answer questions below) ☐ No

i) Did you lose consciousness?
☐ Yes, for _____ minutes / hours / days (circle one only) ☐ No

ii) Was there any bleeding in the brain?
☐ Yes (please provide details below) ☐ No

Details

c) Please describe the symptoms or disabilities that you are now having, if any, as a result of the injury (for example, pain, limp, numbness):

Description of symptoms or disabilities	
Date of first occurrence	
Date of last occurrence	

What is the nature of the symptom or disability (tick one only)?
☐ Acute i.e. one-off
☐ Recurrent. Indicate frequency: (tick one only)
☐ At least 4 times a year ☐ At least 2 times a year ☐ Once a year
☐ Chronic i.e. persisting over a long period of time
☐ Less often than once a year ☐ Others _____

d) Has any investigation (for example, x-ray, blood test, ECG) been done?
☐ Yes (please provide details below) ☐ No

Date	Type of test done	Result

Questions for insured (continued)

Name (as shown in NRIC or FIN)	NRIC number or FIN	Proposal number(s)

2 Treatment

a) Have you seen a doctor for this injury?

☐ Yes (please provide details below) ☐ No

Name and address of doctor	Date of first consultation	Date of last consultation	Result of last consultation

b) Have you ever been hospitalised for this injury?

☐ Yes (please provide details below) ☐ No

Date	Duration of stay	Treatment	Name of hospital

c) i) Have you ever had any surgery done for this injury or is there any intention to do so in the future?

☐ Yes (please provide details below) ☐ No

Date	Nature of procedure	Name of hospital

ii) Was any implant of metal pieces, screws or plates inserted during any of the surgeries?

☐ Yes (please provide details below) ☐ No

Date of implant	Which part of the body the implant was inserted into	Is it still there?	If implant has been removed, date of its removal
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

d) Was there any medication, therapy or other treatment prescribed for this injury?

☐ Yes (please provide details below) ☐ No

Name or description	Dosage	Date or period

Questions for insured (continued)

Name (as shown in NRIC or FIN)	NRIC number or FIN	Proposal number(s)

3 Current Status

Please tick the ones that are applicable and provide the required details.

☐ Have fully recovered on _____ (dd/mm/yyyy)
(i.e. no recurrence, no symptom, no complication and no resulting disability or restriction in activities)

☐ Have been fully discharged from medical follow up on _____ (dd/mm/yyyy)

☐ Still on regular treatment or medical follow-up with doctor or therapist

Frequency	
Date of last consultation	
Date of next consultation	
Name and address of doctor	

☐ Waiting for further investigation or waiting for treatment or surgery

Planned date	
Description	
Name and address of doctor	

☐ Others (please provide details below)

Details

4 Medical Report

Please submit a copy of inpatient discharge summary or investigation or medical report(s).

☐ Attached ☐ Not available

Declaration by the proposer and insured

I declare that the answers in this form are true, correct and complete, and I have not withheld any relevant information. I accept full responsibility for them, whether written by me or by anyone else on my behalf.

I acknowledge and agree that this form will constitute part of my application for life or health insurance, and will form the basis of the contract of insurance. If anything is untrue, incorrect or incomplete, the insurance policy will not be valid.

I confirm that there has been no change in the insured's health since the completion of the application and all additional declarations made in connection with the application.

Signature of proposer	Signature of insured (for age 16 and above)
Date (dd/mm/yyyy):	Date (dd/mm/yyyy):