NTUC Income Insurance Co-operative Limited
Income Centre 75 Bras Basah Road Singapore 189557
Tel: 6332 1133 · Fax: 6338 1500
Email: healthcare@income.com.sg · Website: www.income.com.sg
an NTUC Social Enterprise

Checklist for IncomeShield Outpatient Claim only

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 'V' 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.

(d) We will only process the claims that were incurred on outpatient basis after the hospitalisation/day surgery/outpatient hospital treatment claims have been processed.

☐ **Pre-Hospitalisation Treatment/Post-Hospitalisation Treatment Claim/Prosthesis Benefit [not eligible for IncomeShield Standard Plan]**

_____ IncomeShield Outpatient Claim Form (to be completed by claimant)

_____ ORIGINAL Final hospital/medical bills & receipts (Note: we do not accept scanned copies, photocopies, "duplicate" copies, interim bills, unsettled bills or only receipts)

_____ Referral letter, if applicable

_____ A copy of the reimbursement letter/discharge voucher from the Insurer/Employer/Payslip showing amount deducted (if there is previous reimbursement from another Insurer/Employer)

[Please refer to your policy documents for coverage details. Above benefits may not be eligible for certain types of claims, for example, Inpatient Psychiatric Treatment.]

☐ **Treatments that are carried out as part of chemotherapy/radiotherapy/dialysis and where the chemotherapy/radiotherapy/dialysis treatment are still on-going**

_____ IncomeShield Outpatient Claim Form (to be completed by claimant)

_____ ORIGINAL Final hospital/medical bills & receipts (Note: we do not accept scanned copies, photocopies, "duplicate" copies, interim bills, unsettled bills or only receipts)

_____ A copy of the reimbursement letter/discharge voucher from the Insurer/Employer/Payslip showing amount deducted (if there is previous reimbursement from another Insurer/Employer)

_____ If the outpatient treatments are carried out as part of the ongoing chemotherapy/radiotherapy/dialysis treatment, a doctor memo from your attending physician must be submitted for our review in the case where there is no chemotherapy/radiotherapy/dialysis treatment in the month where the outpatient treatments were incurred. The doctor memo will need to substantiate that the outpatient treatments are carried out as part of the chemotherapy/radiotherapy/dialysis treatment and the date of the chemotherapy/radiotherapy/dialysis treatment

[Please refer to your policy documents for coverage details.

IncomeShield Standard Plan only covers outpatient treatments which take place within 30 days before the chemotherapy/radiotherapy/dialysis treatment, if the limit of compensation has not been fully utilised.]

Remarks: Please note that the above are the basic requirements for outpatient claims in general and are non-exhaustive. You may be required to provide further documents after we review your claim.

Please submit all claim documents at any of our branches , OR through your insurance adviser, OR by post to:

Claims Service Centre
NTUC INCOME Insurance Co-operative Limited
75 Bras Basah Road
INCOME Centre
Singapore 189557

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 **6332 1133** or email us at **healthcare@income.com.sg**.

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IncomeShield Outpatient Claim Form

Important notice
The acceptance of this form is NOT an admission of liability on the part of Income. Any documentary proof or report required by 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 number(s)	Plan type	Related to which claim number	Period of the hospitalisation/day surgery/ outpatient hospital treatment that the outpatient bill(s) is/are related to

Particulars of insured

Name of patient/insured (as shown in NRIC/PP)	NRIC/Passport number	Gender ☐ Male ☐ Female
Occupation (If unemployed, please indicate last occupation)	☐ Employed ☐ Self employed	
Name and address of employer or last employer (if unemployed)	Period of employment (dd/mm/yyyy) From _____ To _____	
Name of policyholder (if different from patient/insured)	NRIC number	Gender ☐ Male ☐ Female
Address		
Contact number (Office) (House) (Hand phone)	Email	

Medical Condition/History

1. Details of illness/injury

Is the condition suffered due to ☐ Illness ☐ Accident

a. If the condition 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 suffered

b. If the injury 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 suffered

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

Medical Condition/History (continued)

2. 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

3. Please describe events that occurred leading to the hospital admission:

Date (dd/mm/yyyy)	Events occurred/symptoms	Doctors seen (name and address)	Period of consultation

4. Has this or similar conditon/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

5. Please provide details of your regular doctor(s) and company doctor(s) below: ☐ Yes ☐ No

Name of doctor	Name and address of clinic/hospital	Date(s) of consultation (dd/mm/yyyy)	Reason(s) for consultation

Other insurances

6. 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

7. 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 conditon/injury? If "Yes", please provide the following informaton. ☐ Yes ☐ No

Name of employer, Insurance company etc.	Policy number	Date of issue (dd/mm/yyyy)	Type of plan	Claim amount	Claim notified (Yes/No)	Claim paid (Yes/No)

Please provide a copy of the respective settlement letter/advice from the other insurance company or other sources.

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 can only claim or be reimbursed for the amount that you have incurred regardless of the number of medical insurance policies you may have. We reserve the right to recover the excess amount paid to you.

Other information

8. Has the policyholder or patient/insured been bankrupt or insolvent or has executed any deed or transfer for the beneft of creditors since becoming interested in the policy? If yes, please state details below. ☐ Yes ☐ No

Payment method

Please tick one of the boxes below to indicate payment method:

☐ Cheque to be mailed directly to the claim recipients

☐ Cheque to be collected by financial adviser

Name of adviser _____

Adviser code _____

☐ Direct credit into the claim recipient's personal individual account **(if you select this option, you will need to provide a copy of claim recipient's bank statement for account verification. Otherwise a cheque will be issued.)**

Name of bank _____

Account holder's name _____

Account number _____

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 application or transaction. It includes all personal data for us to evaluate or administer this application or transaction. For example, if you are applying for an insurance policy, in additon to the personal data provided in the application form, the personal data will also include any subsequent information we collect on health or financial situation, or any information that is necessary for us to decide whether to insure and on what terms to insure, such as test results, medical examination results, and health records from medical practitioners or other insurance companies.

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 (for non-DPS policies);
(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) coach employees and monitor for quality assurance;
(k) reinsure risks and for reinsurance administration; and
(l) 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 or your insured persons for the purposes set out in Section 1 above to these partes:

(a) your financial advisers, insurance broker, association, employer or group policyholder (for non-DPS policies);
(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, 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 (relatng to the servicing and administraton of your insurance policy), 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 result in termination of all non-DPS policies you have with us. It may also result in termination of your DPS policy.

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. You also have the right to request correction of your personal data.

You may make your request to withdraw your consent, 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

Declaration and authorisation

1. I certify that the information in this form is true and complete and I have not withheld any material information.
2. I confirm that I understand and agree to the 'Personal data collection statement'.
3. I agree and authorise:
   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.
4. I 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 a claim under the Dependant's 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.
5. 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.
6. I agree that a photocopy or electronic version of this authorisation shall be as valid as the original.

Name and signature of policyholder (individual)		NRIC number	Date (dd/mm/yyyy)
Name and signature of informant who is 21 years old or above (if the policyholder is unable to sign)	Relationship to policyholder	NRIC number	Date (dd/mm/yyyy)
Please indicate why policyholder is unable to sign			
Name and signature of patient/insured who is 21 years old or above (if different from policyholder)		NRIC number	Date (dd/mm/yyyy)
Name and signature of authorised officer (for group policyholders only)		Date (dd/mm/yyyy)	Company/union stamp