NTUC Income Insurance Co-operative Limited
Income Centre 75 Bras Basah Road Singapore 189557
Tel: 6788 1777 · Fax: 6338 1500
Email: csquery@income.com.sg · Website: www.income.com.sg
an NTUC Social Enterprise

Personal mobility guard 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 them.
- To avoid delay in processing your claim, please send your filled-in 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)
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 (No need to fill this in if the information is the same as above.)

Name (as shown in NRIC, FIN or Passport)	Sex ☐ Male ☐ Female	NRIC, FIN or Passport number	Date of birth(dd/mm/yyyy)
Residential 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

Details of occurrence

1. Date & time of occurrence	2. Place of occurrence
3. Describe circumstances in detail	
4. A detail description (type, brand & model) of bicycle or personal mobility device you were using at the time of accident.	
5. Name & contact number of person who witnessed this occurrence	
6. Is there any other insurance covering this incident? If Yes, please state name of insurance company, policy number and amount recoverable. ☐ Yes ☐ No	

Type of claim

Please tick off the items which you are attaching for this claim. We may ask for more documents to assess this claim.

A. ☐ **Personal Accident** **B.** ☐ **Medical expenses for injury due to an accident**

1. Nature of injury	
2. Did these injuries result in permanent disability? If Yes, please get your attending medical practitioner to complete the attached Attending Medical Practitioner Form. If no, please provide the details. ☐ Yes ☐ No	

3. Amount claimed

Supporting documents required (or attached):

- ☐ Original medical bills
- ☐ Medical report or discharge summary on onset date, cause, extent of permanent disability (if applicable) and nature of injury
- ☐ Police report
- ☐ Death certificate, autopsy report and coroner's findings (death claim)
- ☐ Proof of relationship between deceased and claimant (death claim)

C. ☐ **Personal liability**

1. When were you first notified of the incident?

2. If anyone has been injured, please furnish:

   a) Name, NRIC number and Address of injured person _____

   _____

   b) Details of Nature of Injury / Extent of Damage _____

   _____

   _____

3. Has anyone made a claim against you? If so, by whom?

Note: No payment, offer or promise of any payment or admission of liability should be made. All letters from third parties should be forwarded to us immediately upon receipt.

Supporting documents required (or attached):

- ☐ Police report/investigation results
- ☐ Letters, writ of summons from third party with supporting documents if any (eg. Invoices of items, quotation for repair)

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.

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income made different

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Attending Medical Practitioner's Statement

Part 1 (To be completed by the Insured)

Policy number	Plan type	Claim number
Name of Insured (as shown in NRIC)		NRIC number
Address of Insured		
Name of next-of-kin (if Insured is below age 21 or deceased)	Relationship to Insured	NRIC number
Address of next-of-kin		

Authorisation

I agree and authorise:

a) Any medical institution or medical practitioner, or insurer, or organisation or person to release to NTUC Income any information as requested by Income; and

b) Income to release any relevant information concerning me/my child to any medical institution or medical practitioner, or insurer, or organisation or person.

A photocopy of this form is valid as an original copy.

Signature/Thumbprint of Insured/next-of-kin[1] _____ Date (dd/mm/yyyy) _____

[1] Please delete accordingly

Part 2 (To be completed by Doctor)

Name of Insured (as shown in NRIC)	NRIC number

Height of Insured _____ m Weight of Insured _____ kg

The above readings were taken on this date (dd/mm/yyyy) _____ /_____ /_____

1. a. Are you the Insured's usual doctor?	☐ Yes ☐ No
b. Over what period do your records extend? Start date (dd/mm/yyyy) _____ /_____ /_____ End date (dd/mm/yyyy) _____ /_____ /_____	
2. What is the diagnosis for the Insured's present illness/injury?	
a. What is the exact date of diagnosis? (dd/mm/yyyy) _____ /_____ /_____	
b. Please provide us the name and address of the doctor where the diagnosis was first made.	
c. Was the Insured informed of the diagnosis? If "Yes", when was he first informed? (dd/mm/yyyy) _____ /_____ /_____	☐ Yes ☐ No
d. Is the Insured's present illness or condition caused by any other underlying disorders? If "Yes", please give details.	☐ Yes ☐ No

3. a. Was the condition caused by an accident? If "Yes", please state: Accident date (dd/mm/yyyy) _____ /_____ /_____ Accident time _____	☐ Yes ☐ No
b. Describe the accident.	
c. Was the accident reported to the police? If you happen to possess a copy of the police report, please enclose it.	☐ Yes ☐ No
d. Was the Insured under the influence of alcohol/drugs at the time of accident? If "Yes", please state the blood alcohol content/drug type and quantity consumed.	☐ Yes ☐ No
e. Is the Insured's condition self-inflicted or as a result of suicide? If "Yes", please provide details.	☐ Yes ☐ No

4. Please provide details of the symptoms presented when you first saw the Insured.

Symptoms presented	Duration of symptoms	Date symptoms first occurred (dd/mm/yyyy)

5. Was the Insured referred to you by another doctor? If "Yes", please provide details. ☐ Yes ☐ No

Name of referring doctor	Name & address of clinic/hospital	Date Insured consulted referring doctor (dd/mm/yyyy)	Reason(s) for the referral

6. Did the Insured see any other doctor(s) besides those indicated above? If "Yes", please provide details. ☐ Yes ☐ No

Name of doctor	Name & address of clinic/hospital	Date Insured consulted doctor (dd/mm/yyyy)	Diagnosis made

7. What were the investigations done to confirm the diagnosis?

Please also enclose copies of all reports used in the management of the Insured's condition(s), e.g. biopsy reports, cytology and histopathology reports, x-rays, CT and MRI scans, other imaging studies, laboratory reports, surgical reports, rehabilitation and occupational therapy report, and other relevant reports.

8. a. Please provide details of treatment that has been provided (e.g. surgery, chemotherapy, radiotherapy, physiotherapy, etc.).

Type of treatment	Date of treatment (dd/mm/yyyy)	Duration of treatment	Response to treatment

b. Has the Insured been compliant with the treatment suggested? If "No", please provide details. ☐ Yes ☐ No

c. Are there plans for other forms of treatment? If "Yes", please provide full details. ☐ Yes ☐ No

Type of treatment	Expected date of treatment (dd/mm/yyyy)	Expected response to treatment

e. Has the Insured rejected any treatment that would improve his current condition? If "Yes", please provide us the following: ☐ Yes ☐ No

i. Type(s) of treatment that would improve Insured's condition

ii. How would the treatment improve Insured's condition and to what extent?

iii. Why did Insured reject the treatment?

9. What is the prognosis of the Insured's condition? ☐ Improve ☐ Deteriorate ☐ Remain unchanged

a. Please describe the nature and severity of the Insured's condition.

b. Is full recovery expected? ☐ Yes ☐ No

If "Yes", please state approximate date (dd/mm/yyyy) _____ /_____ /_____

If "No", please state the extent of recovery and approximate date (dd/mm/yyyy) _____ /_____ /_____

c. At your last assessment, does the Insured have any deficits pertaining to his general motor functions? If "Yes", please provide details in (i) to (iv). Date of last assessment (dd/mm/yyyy) _____ /_____ /_____	☐ Yes ☐ No
i. Range and strength (please indicate power grading of limbs)	
ii. Gait and balance	
iii. Coordination	
iv. Movement	
d. Are there any neurological deficits pertaining to the Insured's sensory functions, or other aspects like hearing, smell, visual? If "Yes", please provide details.	☐ Yes ☐ No
10. Is the Insured able to perform all the 6 Activities of Daily Living (feeding, mobility, transferring, washing/bathing, dressing and toileting/continence) independently?	☐ Yes ☐ No
a. If "No", what are the activities the Insured cannot perform independently? Does the Insured require minimal or maximum assistance in these activities?	
b. Is the Insured confined to a home/hospital/or other institution which provides continuous care and medical attention? If "Yes", please provide name and address of this institution, and period(s) of confinement (dd/mm/yyyy).	☐ Yes ☐ No
11. What was the Insured's occupation before his disability?	
a. What was the nature of his duties?	
b. Does the Insured's disability prevent him from performing the above listed duties? If "Yes", please state why.	☐ Yes ☐ No
12. a. Has the Insured returned to his usual occupation?	☐ Yes ☐ No
b. If "No", would the Insured be able to return to his usual occupation at a later date? ☐ Not able to determine presently (Go straight to Question 15) ☐ Yes – Expected date of return to his usual occupation is (dd/mm/yyyy) _____ /_____ /_____ ☐ No – Not possible to return to usual occupation even at a later date	

13. If the Insured cannot return to his usual occupation even at a later date because of his condition, is there any other suitable occupation(s), including sedentary or simpler or desk bound types of occupation (e.g. data entry job, etc.) that he can consider **in the future**?

☐ Yes Examples of such occupation(s) are: _____

Expected date when his condition allows him to engage in these occupation(s) is:

(dd/mm/yyyy) _____ /_____ /_____

If the Insured is unable to engage in sedentary or simpler or desk bound types of occupation (e.g. data entry job, etc.), please provide us the reason(s).

_____

_____

☐ No The Insured is unable to take part in any paid work for the rest of his life.

14. If you have answered "No" to Question 13, please state the date when the Insured is considered not able to take part in any paid work for the rest of his life.

(dd/mm/yyyy) _____ /_____ /_____

15. Is the insured physically or mentally disabled from ever continuing in any employment (including self-employment)? For avoidance of doubt, the difficulty in finding employment is a separate consideration and should not influence your answers to the questions below. ☐ Yes ☐ No

If "Yes", please provide us with reason(s) for your answer and the date (dd/mm/yyyy) when the Insured is permanently incapacitated.

Reason(s):

_____

_____

Date: (dd/mm/yyyy) _____ /_____ /_____

16. If the extent of the Insured's disability cannot be determined at this moment, when would be an appropriate date to assess it?

(dd/mm/yyyy) _____ /_____ /_____

17. Please tick (✔) and answer all applicable sections. Where not applicable, please indicate 'N.A.'

a. Total and permanent loss of sight

The loss must be permanent and irreversible, even with the use of visual aids.

☐ Right eye

Date of total and permanent loss of sight (dd/mm/yyyy)		Date of last review (dd/mm/yyyy)	
Visual acuity		Visual acuity	
Visual field		Visual field	

☐ Left eye

Date of total and permanent loss of sight (dd/mm/yyyy)		Date of last review (dd/mm/yyyy)	
Visual acuity		Visual acuity	
Visual field		Visual field	

Please describe the nature and cause of total and permanent loss of sight.

b. Severance of limbs/total loss of use of limbs

☐ Severance of upper limbs

	Left upper limb	Date (dd/mm/yyyy)	Right upper limb	Date (dd/mm/yyyy)
Severance at or above wrist	☐ Yes ☐ No		☐ Yes ☐ No	
Severance at or above elbow	☐ Yes ☐ No		☐ Yes ☐ No	
Others (please specify: _____)	☐ Yes ☐ No		☐ Yes ☐ No	

Please describe the nature and cause of severance.

☐ Severance of lower limbs

	Left lower limb	Date (dd/mm/yyyy)	Right lower limb	Date (dd/mm/yyyy)
Severance at or above ankle	☐ Yes ☐ No		☐ Yes ☐ No	
Severance at or above knee	☐ Yes ☐ No		☐ Yes ☐ No	
Others (please specify: _____)	☐ Yes ☐ No		☐ Yes ☐ No	

Please describe the nature and cause of severance.

☐ Total loss of use (defined as Total and permanent loss of physical function)

	Date of commencement of loss of use (dd/mm/yyyy)	Please describe the nature and cause of total loss of use
Left upper limb		
Left lower limb		
Right upper limb		
Right lower limb		

Please describe the nature and cause of severance.

18. a. Please describe the Insured's mental and cognitive abilities.

b. Is the Insured mentally incapacitated in accordance to the Mental Capacity Act? ☐ Yes ☐ No

c. If "Yes" to Question 18b above, please state the date when the mental incapacity started.

(dd/mm/yyyy) _____ /_____ /_____

19. Is the Insured suffering or has suffered from any other disease or ailment? If "Yes", please provide full details. ☐ Yes ☐ No

Name of doctor	Name and address of clinic/hospital	Date Insured consulted doctor (dd/mm/yyyy)	Diagnosis made

20. Is the Insured terminally ill, i.e. death is expected within 12 months? If "Yes", please provide details on the basis of your evaluation. ☐ Yes ☐ No

Please indicate the date on which the Insured is assessed to be terminally ill.

(dd/mm/yyyy) _____ /_____ /_____

21. Please provide us with any other information that will be helpful in the assessment of this claim.

_____ _____

Signature of doctor | Date (dd/mm/yyyy)

_____ _____

Name and qualification (printed) | Address and official stamp of clinic/hospital