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

Group Hospital and Surgical Claim Form

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 employer or employee/patient.

2. Upon admission (if applicable), please sign the forms for CPF Medisave Deduction and CPF MediShield Life/Medisave-Approved Integrated Shield Plan and pay a deposit as requested by the hospital.

3. Please submit the following documents within 30 days of the patient's discharge from hospital:
   (a) Please complete all items in Section 1 and indicate as "N.A" if not applicable.
   (b) All final original hospital bills, doctor's bills and receipts of payment.
   (c) For admission into a government/restructured hospital, please provide the inpatient discharge summary/ambulatory form/hospital pre admission form.
   (d) For admission into a private/overseas hospital, please provide the original itemised/detailed hospital bill with Section 2 completed by the attending doctor. If the attending doctor charges a fee for the completion of Section 2 the employer or employee/patient is responsible to pay the charges.
   (e) A copy of the employee's Work Permit or S-Pass. (For claims under WorkMedic Policy only.)
   (f) For bills that indicate any payment by Medisave-Approved Integrated Shield Plan, please provide a copy of the Shield Plan's settlement letter.

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

4. When we pay an eligible claim, precedence shall be given in the following order:
   - Employer or employee if they have 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.

Section 1 – To be completed by employer and employee/patient

Company name: _____ **Policy number:** _____

Particulars of employee or patient

Particulars of employee (as shown in NRIC, FIN or Passport)			
Name (as shown in NRIC, FIN or Passport)	NRIC, FIN or Passport number	Date of birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female
Nationality	Occupation	Date of employment (dd/mm/yyyy)	Contact number
Email address	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.

Particulars of patient (If patient is a dependant of the employee) (as shown in NRIC, FIN, Passport or BC)			
Name (as shown in NRIC, FIN, Passport or BC)	NRIC, FIN, Passport or BC number	Date of birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female
Nationality	Relationship to employee ☐ Spouse ☐ Child	Occupation	

Medical condition

1. Details of illness or injury		
a. Illness or injury	b. Describe symptoms	c. Date the symptoms started (dd/mm/yyyy)
d. Name of hospital	e. Surgical procedure	f. Period of hospitalisation or surgery (dd/mm/yyyy)
g. Name and address of referring General Practitioner or Clinic	h. Name and address of regular General Practitioner or Clinic	

2. Please complete the following if you have sustained injury as a result of an accident

a. Date and time of accident (dd/mm/yyyy)	b. Place of accident	c. Is it Work-related? ☐ Yes ☐ No

d. Give details of how the injury was caused by the accident. (Please enclose a copy of the police report, if any.)

e. Are these medical expenses claimable under your company's Work Injury Compensation Act Policy? ☐ Yes ☐ No

Other information

3. 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. ☐ Yes ☐ No

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.

4. Benefits should be made payable to: ☐ Employer ☐ Employee

Payment to be made by:

☐ Cheque

☐ Credit into employee's bank account [2]

Name of bank _____ Branch _____

Account number _____

[2] The bank details provided must be employee's bank account. If you provide us with an inaccurate bank account number under this section for the payment of this claim, we shall discharge from all liability under this claim and not be liable for any losses incurred by you.

Note: If there is a payment method agreed with your employer, payment will be based on the established method.

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

Certification by employer

Name of employer	Policy number
Effective date of patient's insurance (dd/mm/yyyy)	Plan type
Date the employee last worked (dd/mm/yyyy)	

This is to certify that the details of the employee or insured member in this form is true and complete.

Name of authorised personnel	Signature and company's stamp	Date (dd/mm/yyyy)

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Attending Physician's Statement

Section 2 – To be completed by the Attending Doctor
(Applicable for hospitalisation or day surgery at private/overseas hospital or clinic)

Note: If the space provided is insufficient, please attach any written reports/diagnostic or lab-tests results.

1. Name of patient (as shown in NRIC, FIN, Passport or BC)	2. NRIC, FIN, Passport or BC number of patient
3. Date admitted (dd/mm/yyyy)	4. Date discharged (dd/mm/yyyy)

5. When did the patient first consult you for the condition? (dd/mm/yyyy)

6. Subsequent consultation dates (dd/mm/yyyy)

7. What were the complaints or symptoms presented during the first consultation?

8. When the patient first experienced these complaints or symptoms? (dd/mm/yyyy)

9. What was patient's diagnosis(es)?	First diagnosed date (dd/mm/yyyy)
1.	1.
2.	2.
3.	3.

Note: If there is more than one diagnosis, please advise whether they are related directly or indirectly to each other. Please provide us with details to your answer. ☐ Yes ☐ No

10. What was the underlying cause(s) of the diagnosed condition(s) as stated in Question 9?	Diagnosed date (dd/mm/yyyy)
1.	1.
2.	2.
3.	3.

11. Were any diagnostic or laboratory tests done? If 'Yes', please enclose a copy of the tests results.	☐ Yes ☐ No
12. Has the patient received any prior treatment for this condition before consulting you? If 'Yes', please state when and provide us with the name and address of doctor who treated the patient previously.	☐ Yes ☐ No
13. Was patient referred to you by a clinic or hospital? If 'Yes', please state when was the referral and name and address of the referring doctor.	☐ Yes ☐ No
14. Did patient suffer similar or related conditions in the past? If 'Yes', please indicate nature of problem, name and address of attending doctor and dates of treatment.	☐ Yes ☐ No
15. Has the patient ever suffered from any serious illnesses (e.g. heart conditions, kidney failure, stroke, cancer etc) prior to this admission? If 'Yes', please provide us with the diagnosis, first date of diagnosis, and name and address of doctor seen.	☐ Yes ☐ No

16. Date and type of operation or treatment performed. For surgery, please state surgical table and code. If no surgery was performed, please state treatment and medication given.		
17. Where 2 or more surgical procedures were performed, please specify whether they were done through the same incision.		
18. When was the patient <u>first</u> advised to have the surgery? Name and address of the doctor who advised the patient to have the surgery.		
19. Was the treatment medically necessary? If 'No', please give details.	☐ Yes	☐ No
20. Was the hospitalisation/surgery for the following treatment items, procedures, conditions, activities or their related complications?		
a) Health screening related examinations, admission for diagnostic purpose, genetic screening, treatment of a preventive nature, cosmetic treatment, surgery/treatment for obesity, correction of eye refraction, squint or other eye misalignment? If 'Yes', please give details.	☐ Yes	☐ No
b) Birth defects, congenital abnormalities, or developmental delay/learning disabilities in children? If 'Yes', please give details.	☐ Yes	☐ No
c) Psychological disorder, personality disorder, behavioural disorder, emotional or mental conditions or illness/injury resulting from such disorders? If 'Yes', please give details.	☐ Yes	☐ No
d) Elective abortion, pregnancy or complication arising from pregnancy, complications arising during or after childbirth? If 'Yes', please give details.	☐ Yes	☐ No
e) Infertility, sub-fertility, assisted conception, erectile dysfunction, impotence or contraceptive treatment? If 'Yes', please give details.	☐ Yes	☐ No
f) Venereal diseases, AIDS, AIDS related complex or infection by Human Immunodeficiency Virus (HIV)? If 'Yes', please give details.	☐ Yes	☐ No
g) Intentional, self-inflicted injuries or injuries resulting from attempted suicide? If 'Yes', please give details.	☐ Yes	☐ No
h) Drug addiction or alcoholism or illness/injury resulting from or under the influence of alcohol or drugs? If 'Yes', please give details.	☐ Yes	☐ No
i) Dental treatment, oral surgery, orthodontics, orthognathic surgery, oral and maxillofacial surgery or temporo-mandibular joint disorder? If 'Yes', please give details.	☐ Yes	☐ No
j) An accident? If 'Yes', please give details of the accident and whether it is work-related and whether police report was made.	☐ Yes	☐ No
21. Has patient fully recovered from the condition(s)? If 'No', what are the follow-up treatments required?		

Name and stamp of attending doctor

Signature of attending doctor

Date (dd/mm/yyyy)

Hospital or clinic's name and address