

## ElderShield/ElderShield Supplement/Care Secure Claim Form

Dear Policyholder

We are sorry to learn of your disability.

In order for us to process your claim, please:

1. Complete the attached Claim Form as best as you can. If you are unable to do so, please have it completed by your immediate family member or caregiver.
2. Call the clinic to make an appointment for the disability assessment. Please refer to the list of appointed assessors at <http://www.income.com.sg>. The fee for the assessment is to be paid by you. Please note that this is required in order for the assessor to proceed with the assessment.
3. Bring along the following for the appointment:
  - a. Completed ElderShield/ElderShield Supplement/Care Secure Claim Form
  - b. A copy of your NRIC and the payee's NRIC (if payee is other than the Policyholder)
  - c. Completed Letter of Undertaking and Indemnity (if payee is other than the Policyholder)
  - d. Hospital medical records and Inpatient discharge summary. Please note that this is required in order for the assessor to proceed with the assessment.
  - e. Medicine (if any)

Once we have received all the required documents/information, we will process your claim and inform you of the outcome as soon as possible.

If you need help, please contact our customer service officers on **6332 1133** or email us at [healthcare@income.com.sg](mailto:healthcare@income.com.sg).

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## 乐龄健保 索赔表格

亲爱的保户：

我们对您的健康状况深感遗憾。

为了尽快处理您的索赔，请您：

1. 填写随附的索赔表格。您的家人或看护也可替您填写。
2. 登录我们的网站 <http://www.income.com.sg> 查阅我们所指定的评估医生名单，并致电与其中任何一位医生预约，对您的健康状况进行评估。评估费用将由您承担。
3. 于评估当日须携带以下文件：
  - a. 填写的乐龄健保索赔表格（ElderShield/ElderShield Supplement/Care Secure Claim Form）
  - b. 你的身份证和收款人的身份证（如果收款人不是保户）
  - c. 填写的担保书（如果收款人并非保户）（Completed Letter of Undertaking and Indemnity）
  - d. 医院医疗记录和出院报告。这些文件是必需的，以便评估员对您的索赔进行评估。
  - e. 药物（如有）

我们在收到所需的全部文件／资料后会尽速处理您的索赔，并及时通知您索赔的结果。

如果您需要任何协助，请致电 **6332 1133** 与我们的客户服务人员联系，或发送电邮给我们，邮址是：  
[healthcare@income.com.sg](mailto:healthcare@income.com.sg)。

## BORANG TUNTUTAN ElderShield/ElderShield Supplement/Care Secure

Pemegang polisi,

Kami bersimpati dengan keadaan kesihatan anda.

Untuk membolehkan kami memproses tuntutan anda, sila:

1. Lengkapkan Borang Tuntutan yang dilampirkan dengan sedaya upaya yang anda mampu. Jika anda tidak dapat berbuat demikian, sila minta ahli keluarga atau penjaga anda untuk mengisikannya.
2. Hubungi klinik untuk membuat temujanji bagi penilaian ketidakupayaan. Anda boleh rujuk kepada senarai penilai yang dilantik daripada lelaman kami (<http://www.income.com.sg>). Anda juga dikehendaki membayar yuran penilaian sendiri.
3. Bawa dokumen berikut semasa temujanji:
  - a. Borang Tuntutan ElderShield yang telah dilengkapi.
  - b. Salinan kad pengenalan anda dan penerima tuntutan (jika penerima tuntutan bukan pemegang polisi insurans)
  - c. Surat Akujanji dan Tanggung Rugi yang telah dilengkapi (jika penerima tuntutan lain daripada pemegang polisi)
  - d. Rekod perubatan hospital dan ringkasan/surat pelepasan pesakit (Inpatient Discharge Summary). Sila ambil perhatian bahawa ini diperlukan agar penaksir boleh memulakan dengan taksiran.
  - e. Ubat-ubatan (jika ada)

Setelah kami menerima semua dokumen/maklumat yang diperlukan, kami akan memproseskan tuntutan anda dan memberitahu keputusannya dengan secepat mungkin.

Sekiranya anda memerlukan sebarang bantuan, sila hubungi pegawai khidmat pelanggan kami di talian **6332 1133** atau emel kami di [healthcare@income.com.sg](mailto:healthcare@income.com.sg).

### எல்டர்ஷீல்டு கோரிக்கை படிவம்

அன்புள்ள பாலிசிதாரர்

தங்களுக்கு ஏற்பட்டுள்ள இயலாமை நிலை அறிந்து வருந்துகிறோம்.

மேற்கொண்டு நாங்கள் செயலாற்ற அன்பு கூர்ந்து பின் வருவனவற்றை செய்யுங்கள்:

1. இணைக்கப்பட்டுள்ள கோரிக்கை படிவத்தை தங்களால் இயன்ற வரை பூர்த்தி செய்யுங்கள். தங்களால் இயலவில்லை என்றால், நெருங்கிய குடும்ப உறுப்பினரோ அல்லது தங்களைத் தற்போது கவனித்துக்கொள்பவரோ பூர்த்தி செய்யலாம்.
2. தங்களுடைய இயலாமை நிலையை மதிப்பிடுவதற்கான மருத்துவப் பரிசோதனை செய்துகொள்ள நாள்குறிப்பதற்கு மருந்தகத்தை அழையுங்கள். நியமன மருத்துவ மதிப்பிட்டாளர் பட்டியலை <http://www.income.com.sg> என்ற இணையத் தளத்தில் காண்க. மருத்துவப் பரிசோதனை கட்டணத்தை நீங்கள் கொடுக்க வேண்டும் என்பதையும் தெரிவித்துக்கொள்கிறோம்.
3. பரிசோதனைக்கு செல்லும் போது பின் வருவனவற்றை எடுத்துச் செல்லுங்கள்:
  - a. பூர்த்தி செய்யப்பட்ட எல்டர்ஷீல்டு கோரிக்கை படிவம்
  - b. உங்கள் அடையாள அட்டை மற்றும் பணம் பெருபவரின் அடையாள அட்டையின் நகல் (பணம் பெறுபவர் பாலிசிதாரர் இல்லாமல் வேறொருவராக இருந்தால்)
  - c. பூர்த்தி செய்யப்பட்ட பொறுப்பேற்பு மற்றும் சட்ட விலக்குரிமைக் கடிதம் (பணம் பெறுபவர் பாலிசிதாரர் இல்லாமல் வேறொருவராக இருந்தால்)
  - d. உங்களிடம் இருக்கிற நோய் தொடர்பான தகவல்கள் (மருத்துவ அறிக்கைகள் மற்றும் மருத்துவமனையிலிருந்து வீட்டிற்குத் திரும்பியபோது தரப்பட்ட மருத்துவக் குறிப்புகள்). இந்த மதிப்பீட்டை தொடர மதிப்பீட்டாளருக்கு இது அவசியம் என்பதை தயவு செய்து நினைவில் கொள்ளவும்.
  - e. உட்கொள்ளும் மருந்துகள் (அவை இருந்தால்)

அனைத்து தகவல்களும் புத்திரங்களும் எங்களுக்கு கிடைத்தவுடன் உங்கள் கோரிக்கையை பரிசீலனை செய்து முடிவை கூடிய விரைவில் உங்களுக்கு தெரியப்படுத்துவோம்.

உங்களுக்கு உதவி தேவைப்பட்டால், தயவு செய்து **6332 1133** எண்ணில் எங்கள் வாடிக்கையாளர் சேவை அதிகாரிகளை அழைக்கவும் அல்லது [healthcare@income.com.sg](mailto:healthcare@income.com.sg) என்ற முகவரிக்கு மின்னஞ்சல் அனுப்பவும்.

## ElderShield/ElderShield Supplement/Care Secure Claim Form

### To be completed by Policyholder

Please complete the following:

**Basic ElderShield** Policy number \_\_\_\_\_ Insurer: Aviva/Great Eastern/Income<sup>1</sup>

**ElderShield Supplement** Policy number \_\_\_\_\_ Insurer: Aviva/Great Eastern/Income<sup>1</sup>

**Care Secure** Policy number \_\_\_\_\_

### Personal particulars

#### Policyholder

Name of policyholder (as shown in NRIC)

NRIC number	Nationality	Date of birth (dd/mm/yyyy)	Ethnic group <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Malay <input type="checkbox"/> Others	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Address

Contact number (Handphone) _____ (Office) _____ (Home) _____	Email _____
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#### Caregiver (Age above 21 years old)

Name of caregiver (full-time or part-time)<sup>1</sup> \_\_\_\_\_ Nationality \_\_\_\_\_

Address of caregiver

Relationship to policyholder	NRIC number
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Contact number (Handphone) _____ (Office) _____ (Home) _____	Email _____
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#### Bank account for benefits payment once claim is admitted

**Note: For payment to third party (family member or caregiver), please complete the attached Letter of Undertaking & Indemnity.**

Name of bank account holder	Bank account number
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Name of bank	Name of branch
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#### Details of dependant (for Care Secure only) or child below age 21 (for PrimeShield only)

Name of dependant/youngest child	Date of birth (child)	Place of birth (child)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Birth certificate/NRIC number (Please submit copy of birth certificate/NRIC)	If the child is legally adopted, please state Date of Adoption (dd/mm/yyyy): _____ <i>(Please submit copy of legal adoption papers)</i>
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### Medical history

1. Have you ever been admitted to a hospital in the last 5 years?  Yes  No If "Yes", please give details of the medical conditions and when it started.

Condition	Date started (dd/mm/yyyy)

2. Please state other medical conditions, if any (e.g. stroke, hypertension, heart disease, diabetes mellitus) that you are suffering from.

3. Name and address of your regular doctor.

4. If disability is due to accident, please provide date of accident \_\_\_\_\_ (dd/mm/yyyy), and attach a copy of accident report.  
If no report is available, please describe: (a) nature of the accident; and (b) extent of injuries sustained.

<sup>1</sup> Please delete whichever is not applicable.

## Personal data use statement

By providing the information and submitting this application or transaction, I/we consent and agree to NTUC Income Insurance Co-operative Limited, its representative, agents (collectively "Income"), relevant third parties, referred to in Income's Privacy Policy which can be found at <https://www.income.com.sg/privacy-policy> and/or appointed distribution partners to collect, use, and disclose my/our personal data and information (including any updates and existing personal data that I have/had given to Income) (collectively "personal data") for the purposes of processing and administering the insurance application or transaction, providing me with financial advice and/or recommendation on products and services, managing my relationship and policies with Income including sending me corporate communications and notices on updates and servicing, research and data analytics, and in the manner and for the purposes described in the Income's Privacy Policy.

Where personal data of a third party (for example personal data of my spouse, child, ward, parent or employee) is provided by me/us, I/we represent and warrant that I/we have obtained the consent of the third party to provide Income with their personal data for this application or transaction.

For the purpose of this application and any claim in connection with my/our policy(ies) with Income, I/we also authorise, agree and consent to (whether this application or transaction is accepted or refused) the following:

- a. The medical source, insurance office, reinsurer, or organisation to release to Income any medical or relevant information to do with me or the insured
- b. Income to collect from and/or disclose to any medical source, insurance office, reinsurer, or organisation any medical or relevant information to do with me or the insured;
- c. Income or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests for Income to underwrite and evaluate me or the insured health status or condition in relation to this application and any claim in connection with my/our policy(ies) with Income.

When submitting a claim for an insurance policy, the personal data will also include any subsequent information Income collects on health or any information that is necessary for Income to decide whether to pay the claim, such as test results, medical examination results, and health records from medical practitioners.

I/we authorise, consent and agree to NTUC Income Insurance Co-operative Limited disclosing my/our personal data to the Government of Singapore and statutory boards and organisations approved by the Government of Singapore, for the purpose of determining my suitability and eligibility for public schemes (including, without limitation, schemes relating to healthcare, aged care, disability, social assistance, financial assistance, retirement, savings, insurance and/or disability insurance) when required.

Please refer to Income's Privacy Policy for more information, including access and correction of my personal data and consent withdrawal.

I confirm that I understand and agree to the collection, use and disclosure of my personal data as stated in the "Personal Data Use Statement" above.

## Declaration and authorisation

**If the Policyholder has previously been assessed by a doctor to lack mental capacity\*, the Policyholder's appointed donee(s)/deputy(s), or caregiver if a donee(s)/deputy(s) has not been appointed, is to complete this section and sign/affix thumbprint. The mentally incapacitated Policyholder need not sign off/affix thumbprint.**

\* A separate doctor's memo should be submitted to indicate that the Policyholder lacks mental capacity, including the relevant medical reason(s).

1. I certify that the information in this form is true and complete and I have not withheld any material information.
2. I agree that this application shall form part of my application for ElderShield/Care Secure benefits.
3. I/We declare that I/we am/are not an undischarged bankrupt or insolvent or has/have executed any deed or transfer for the benefit of creditors within the last twelve (12) months.
4. I confirm that I understand and agree to the 'Personal data use statement'.
5. For the purpose of policy administration including processing and investigating this claim (whether this application is accepted or refused), 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, reinsurer and investigative agencies, to release and exchange such information (including personal health information) requested by Income and/or its service providers.
  - b. I authorise Income to collect from and/or disclose to and to exchange with any medical source, insurance office, reinsurer, or organisation any relevant information to do with me/us.
  - c. I authorise Income or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests for Income to underwrite and evaluate my/our health status or condition in relation to this application and any claim in connection with this policy.
  - d. I am authorised to disclose information (including personal health information) about the insured person if this claim is made on behalf of him/her.
6. I agree that a photocopy or electronic version of this authorisation shall be as valid as the original.

Name of Policyholder	NRIC number	Signature or thumbprint of Policyholder	Date (dd/mm/yyyy)
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### To be completed if form is filled up by family member

Name of family member	NRIC of family member	Relationship to Policyholder
Address of family member	Signature of family member	Date (dd/mm/yyyy)
Contact number (Handphone)	(Office)	(Home)

**Important Note:**

- 1. This Letter of Undertaking and Indemnity is a legal document. Please seek legal advice if you have any enquiries. Your completion of this letter will facilitate the prompt processing of your claim.
- 2. Please complete this form if payment is to be made to a Third Party.

**To be completed by payee**

To: Income

**Part I: Letter of Undertaking & Indemnity**

I/We declare that I am/we are the main caregiver(s) of the Policyholder, \_\_\_\_\_  
Name of Policyholder  
\_\_\_\_\_ of NRIC number \_\_\_\_\_  
NRIC number of Policyholder  
Policy number \_\_\_\_\_

In consideration of Income agreeing, at the Policyholder's/my/our request to pay the benefits which the Policyholder is entitled to under Income's ElderShield and/or ElderShield Supplements or Care Secure insurance ("the Benefits") to me/us, I/we agree and undertake as follows :

- 1. That I/we will first use and apply the Benefits paid by Income for the care and benefit of the Policyholder.
- 2. That I/we will inform Income immediately upon becoming aware that the Policyholder has passed away or ceases to be entitled to the Benefits. I/we will repay any Benefits which the Policyholder is not entitled or ceases to be entitled to upon written demand by Income.

I/We agree and undertake that if I/we fail to make such repayment, I/we will fully indemnify Income against any loss, damage, cost and expense whatsoever, including any legal cost on a full indemnity basis, which may be incurred by Income as a result of my/our failing to fully repay the benefits or if Income has to enforce its rights under this Undertaking and Indemnity.

**Part II: Direct credit authorisation**

**Kindly attach a copy of the bank book or statement showing the bank's name, branch and account number for our action.**

I authorise Income to credit the Benefits into this account and to verify my/our account with the bank:

Name of account holder(s) : \_\_\_\_\_

Name of bank : \_\_\_\_\_

Name of branch : \_\_\_\_\_

NRIC number : 

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Account number : 

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**Details of payee (Age above 21 years old)**

Full Name of payee	NRIC number	Contact number
Address		Nationality
Signature of payee	Relationship to Policyholder	Date (dd/mm/yyyy)
Full Name of Policyholder	Signature/thumbprint of Policyholder	Date (dd/mm/yyyy)

**For homes or institutions only (If benefits are to be made to the home or institution)**

Name of home or institution		Address of home or institution	
Name of authorised officer	Contact number of authorised officer	Official stamp of home or institution	
Signature of authorised officer	Date (dd/mm/yyyy)		
Full Name of Policyholder		Signature/thumbprint of Policyholder	Date (dd/mm/yyyy)