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

30-day Protect Data Plan Free Cover 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 it.
- To avoid delay in processing your claim, please send your completed claim 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 of policyholder (as shown in NRIC)	NRIC number	Date of birth (dd/mm/yyyy)
Home address	Occupation	Nationality
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 (Do not fill this in if it is the same as above)

Full name (as shown in NRIC)	NRIC number	Date of birth (dd/mm/yyyy)
Home address	Occupation	Nationality
Contact number. (Office) (Home) (Handphone)	Email	

Payee's details

With immediate effect, we will ONLY make payment via direct transfer to Policyholder's bank account. Please indicate the bank details below clearly for us to process the payment and to avoid any delay to the claim settlement.

Full name (as shown in the bank account)	Nationality	Name of Bank	Bank Account Number

Details of incident, injury or illness

Date of incident (dd/mm/yyyy)	Time of incident ☐ am ☐ pm	Place of incident
Say what happened		
Nature and extent of injury or illness sustained		

1. Has the insured person previously suffered a similar injury or illness? ☐ Yes ☐ No
   If Yes, please give details.

2. How long was the hospital stay?

Supporting documents

(A) If you are claiming for **Accidental death**, please send to us the following.

1. A copy of the death certificate
2. The autopsy report, toxicological report and coroner's findings
3. Proof of your relationship with the person who died

Policyholder or person claiming	Documents needed
Husband or wife	Marriage certificate
Parent	Birth certificate of person who has died
Child	Birth certificate of policyholder or person claiming
Brother or sister	Birth certificate of person who has died and policyholder or person claiming

4. Newspaper clipping and police or accident report
5. Last will of the person who died (if they left a will) or letter of administration (if there is no will)

(B) If you are claiming for **Permanent disability**, please send to us the following.

1. Inpatient discharge summary (if you have to stay in hospital)
2. Newspaper clipping and police or accident report
3. A filled-in medical report (see 4th page of the claim form)

(C) If you are claiming for **Daily hospital income after more than 4 days of hospitalisation due to an accident**, please send to us the following.

1. A copy of the final hospital bill
2. Inpatient discharge summary (if you have to stay in hospital)
3. Newspaper clipping and police or accident report
4. A filled-in medical report (see 4th page of the claim form)

(D) If you are claiming for **Get well benefit after more than 4 days of hospitalisation due to an accident or sickness**, please send to us the following.

1. A copy of the final hospital bill
2. Inpatient discharge summary
3. Newspaper clipping and police or accident report
4. A filled-in medical report (see 4th page of the claim form)

(E) If you are claiming for **Job loss after more than 4 days of hospitalisation due to an accident or sickness**, please send to us the following.

1. A copy of the final hospital bill
2. Inpatient discharge summary
3. Newspaper clipping and police or accident report
4. A filled-in medical report (see 4th page of the claim form)
5. Letter from employer stating the reason of termination is due to no longer medically fit to perform the major duties connect with your employment

This is not a full list and we may ask for other documents.

Personal data use statement

By providing the information and submitting this form, I/we give my/our consent 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 the information (including any updates) for the purposes of processing and administering this 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 information 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.

The consent provided by me in this form is in addition to and does not supersede any consent which I may have provided previously in respect of the above purposes, unless my consent is withdrawn and notified to Income.

I may withdraw my above consent by contacting Income Contact Centre at 6788 1777 or submitting my request via Income website at https://www.income.com.sg/contact-us/customer-enquiry-form.

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

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 use 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: _____

Signature: _____

Date (dd/mm/yyyy) : _____

Name of insured: _____

Signature: _____

Date (dd/mm/yyyy) : _____

Claim submission instruction

You may email the completed claim form and supporting documents to plineclaims@income.com.sg. Please keep the original copy of the supporting documents for 6 months as we may request for them on case by case basis prior to settlement of the claim.

Medical report

The doctor must fill this in.
(You will have to pay any costs involved in the doctor providing this report.)

Name of Patient	NRIC number

1. Final diagnosis

2. Date of diagnosis (dd/mm/yyyy)

3. Nature of injury or condition and the extent of the injury

4. Was the condition caused by an accident? ☐ Yes ☐ No

   a) If Yes, please give: the date of the accident (dd/mm/yyyy): _____ Time of accident: _____ AM/ PM

   Describe the accident

   _____

   b) If No, please state the cause of condition:

   _____

5. Was any surgery carried out for this condition? ☐ Yes ☐ No
   If Yes, please provide nature of treatment/name(s) of surgical procedure(s), surgical code & table.

6. Was the insured under the influence of alcohol or drugs at the time of the accident? ☐ Yes ☐ No
   If Yes, please state the blood alcohol content or type of drug and the quantity consumed.

7. Is the Insured's condition self-inflicted or as a result of attempted suicide? If Yes, please provide details. ☐ Yes ☐ No

8. Is the injury likely to cause loss of use of the injured part? ☐ Yes ☐ No

9. Is the loss likely to be permanent? ☐ Yes ☐ No
   If Yes, to what extent (as a percentage of disability) and the date (dd/mm/yyyy) the loss is confirmed to be permanent.

For illness (if this applies)

1. Date of symptom first started (dd/mm/yyyy)	2. When did the patient first consult you about this condition?

3. Details of present symptoms, nature and date of treatment given

4. What were the underlying conditions? Please provide date of diagnosis

5. Doctors previously consulted by the patient for the above condition:

Name of doctor	Date of consultation	Name of clinic or hospital	Address

6. Has the patient fully recovered from the condition? If No, what follow up treatment are needed?

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

_____ _____
Name and position Name and address of clinic or hospital