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

ElderShield 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 Claim Form
   b. Completed Letter of Undertaking and Indemnity (if payee is other than the Policyholder)
   c. Hospital medical records and Inpatient discharge summary. Please note that this is required in order for the assessor to proceed with the assessment.
   d. 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**.

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. 填妥随附的索赔表格。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. 填妥的乐龄健保索赔表格（ElderShield Claim Form）
   b. 填妥的担保书（如果收款人并非保户）（Completed Letter of Undertaking and Indemnity ）
   c. 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。
   d. 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**。

income
made different

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BORANG TUNTUTAN ElderShield

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. Surat Akujanji dan Tanggung Rugi yang telah dilengkapi (jika penerima tuntutan lain daripada pemegang polisi)
   c. Rekod perubatan hospital dan ringkasan/surat pelepasan pesakit (Inpatient Discharge Summary). Sila ambil perhatian bahawa ini diperlukan agar penaksir boleh memulakan dengan taksiran.
   d. Ubat-ubatan (jika ada)

Setelah kami menerima semua dokumen/maklumat yang diperlukan, kami akan memproseskan tuntutan anda dan memberitahu keputusannya denga 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**.

எல்டர்ஷீல்டு கோரிக்கை படிவம்

அன்புள்ள பாலிசிதாரர்

தங்களுக்கு ஏற்பட்டுள்ள இயலாமை நிலை அறிந்து வருந்துகிறோம்.

மேற்கொண்டு நாங்கள் செயலாற்ற அன்பு கூர்ந்து பின்வருவனவற்றை 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 நீங்கள்கொடுக்க வேண்டும் என்பதையும் தெரிவித்துக்கொள்கிறோம்.

3. பரிசோதனைக்கு செல்லும் போது பின்வருவனவற்றை எடுத்துச் செல்லுங்கள்:
   a. பூர்த்தி செய்யப்பட்ட எல்டர்ஷீல்டு கோரிக்கை படிவம்
   b. பூர்த்தி செய்யப்பட்ட பொறுப்பேற்பு மற்றும் சட்ட விலக்குரிமைக் கடிதம் (பணம் பெறுபவர் பாலிசிதாரர் இல்லாமல் வேறொருவராக இருந்தால்)
   c. உங்களிடம் இருக்கிற நோய் தொடர்பான தகவல்கள்(மருத்துவ அறிக்கைகள் மற்றும் மருத்துவமனையிலிருந்து வீட்டிற்குத் திரும்பியபோது தரப்பட்ட மருத்துவக் குறிப்புகள்). **இந்த மதிப்பீட்டை தொடர மதிப்பீட்டா**ளருக்கு இது அவசியம் என்பதை தயவு செய்து நினைவில் கொள்ளவும்.
   d. உட்கொள்ளும் மருந்துகள்(அவை இருந்தால்)

அனைத்து தகவல்களும் பத்திரங்களும் 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** என்ற முகவரிக்கு மின்னஞ்சல் அனுப்பவும்.

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ElderShield Claim Form

To be completed by Policyholder

Please complete the following:

Basic ElderShield Policy number _____ Insurer: Aviva/Great Eastern/Income[1]

ElderShield Supplement Policy number _____ Insurer: Aviva/Great Eastern/Income[1]

Personal particulars

Policyholder				
Name of policyholder (as shown in NRIC)				
NRIC number	Nationality	Date of birth (dd/mm/yyyy)	Ethnic group ☐ Chinese ☐ Indian ☐ Malay ☐ Others	Gender ☐ Male ☐ Female
Address				
Contact number (Handphone) (Office) (Home)			Email	
Caregiver (Age above 21 years old)				
Name of caregiver (full-time or part-time)[1]				
Address of caregiver				
Relationship to policyholder			NRIC number	
Contact number (Handphone) (Office) (Home)			Email	
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	
Name of bank			Name of branch	
Details of child below age 21 (Applicable to PrimeShield only)				
Name of youngest child		Date of birth (dd/mm/yyyy)	Place of birth	Gender ☐ Male ☐ Female
Birth certificate number (*Please submit copy of birth certificate of child*)			If the child is legally adopted, please state Date of Adoption (dd/mm/yyyy): _____ (*Please submit copy of legal adoption papers*)	

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.

[1] *Please delete whichever is not applicable.*

Activities of daily living

Please tick against the box that most accurately describes the Policyholder's ability.	Date disability started (dd/mm/yyyy)
1. **Washing or bathing** - Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means. ☐ No help is needed ☐ Some help or supervision is needed (e.g. to wash the back, to wash hair) ☐ Needs someone to help most of the time ☐ Not able to do at all (needs to be washed or bathed entirely by caregiver)	
2. **Dressing** - Ability to put on, take off, secure and unfasten all garments (upper and lower) and, as appropriate, any braces, artificial limbs or other surgical or medical appliances. ☐ No help is needed ☐ Some help or supervision is needed (e.g. to button clothes, to put on trousers) ☐ Needs someone to help most of the time ☐ Not able to do at all (needs to be dressed entirely by caregiver)	
3. **Feeding** - Ability to feed oneself food after it has been prepared and made available. ☐ No help is needed ☐ Some help or supervision is needed (e.g. to scoop food, to put food into mouth) ☐ Needs someone to help most of the time ☐ Not able to do at all (needs caregiver to feed entirely or is tube-fed)	
4. **Toileting** - Ability to use the lavatory or manage bowel and bladder functions through the use of protective undergarments or surgical appliances if appropriate. ☐ No help is needed ☐ Some help or supervision is needed (e.g. to get on or off the toilet) ☐ Needs someone to help most of the time ☐ Not able to do at all (needs to be placed on the toilet and cleaned by caregiver) ☐ Not able to do at all (needs caregiver to manage diapers and/or catheter)	
5. **Transferring** - Ability to move from a lying position on the bed to an upright chair or wheelchair, and vice versa. ☐ No help is needed ☐ Some help or supervision is needed (e.g. to be lifted up from lying position to sitting position from bed) ☐ Needs someone to help most of the time ☐ Not able to do at all (needs to be carried)	
6. **Mobility** - Ability to move indoors from room to room on level surfaces. ☐ No help is needed ☐ Some help or supervision is needed (e.g. to be supervised by someone closely in case of fall) ☐ Needs someone to help most of the time ☐ Not able to do at all (needs to be carried)	

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 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) communicate on purposes relating to an application or policy;
   (c) decide whether to insure or continue to insure you and your insured persons;
   (d) provide financial advice for product recommendation based on your financial needs analysis;
   (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;
(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;
(k) regulators, law enforcement and government agencies; and
(l) the Government and participating statutory boards and organisations approved by the Government to determine your and your insured person's suitability and eligibility for social and public assistance schemes.

Neither Income nor any of its officers shall be liable for any loss or damage suffered by you or any user as a result of any disclosure of any personal data which you have consented to Income and/or any of its officers disclosing.

3. Consequence of withdrawing consent to the collection, use and disclosure of personal data

You may refuse to give, or may 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.

However, if you withdraw your consent for us to use your personal data for your insurance matters (relating to the servicing and administration 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 may result in termination of all your policies you have with us. This may be disadvantageous to you, as you may lose valuable benefits from the policy and/or it may not be possible for you to obtain a similar level of protection on the same terms in the future.

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

You may refer to Income's Privacy Policy for more information in our website. Privacy Policy: (https://www.income.com.sg/privacy-policy)

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 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 collection statement'.
5. 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.
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)

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 or having agreed, at the Policyholder's/my/our request to pay the benefits which the Policyholder is entitled to under Income's ElderShield insurance ("the ElderShield Benefits") to me/us, I/we agree and undertake as follows:

1. That I/we will use and apply the ElderShield Benefits paid by Income only 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 ElderShield Benefits. I/We will repay any ElderShield 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 ElderShield Benefits or if Income has to enforce its rights under this Undertaking and Indemnity.

Part II: Letter of Undertaking & Indemnity to the Government of the Republic of Singapore for Pioneer Generation Disability Assistance Scheme (PioneerDAS)

This Part applies where the Policyholder named in Part I ("Pioneer") is determined to be eligible for and is accepted into the Pioneer Generation Disability Assistance Scheme (PioneerDAS)*, a Government scheme administered by the Agency for Integrated Care (AIC).

To: the Government of the Republic of Singapore

- I/We declare that I am/we are the main caregiver(s) of the Pioneer.
- I/We agree and undertake as follows:
- I/We will use the PioneerDAS payments only for the care and benefit of the Pioneer.
- I/We will inform AIC immediately in writing if the Pioneer has passed on or ceases to satisfy the PioneerDAS Eligibility Criteria*
- Upon written demand by AIC, I/ we will refund to AIC any PioneerDAS payments paid after the Pioneer ceases to be eligible for such payments.
- I/We will fully indemnify AIC and the Government of the Republic of Singapore against any loss, damage, cost and expense whatsoever, including any legal cost on a full indemnity basis, which may be incurred as a result of my failing to abide by the terms of this Undertaking and Indemnity.

* Eligibility Criteria for PioneerDAS is as follows:

- The Pioneer is born on or before 31 December 1949;
- The Pioneer is a citizen of Singapore on or before 31 December 1986, and remains a Singapore citizen;
- The Pioneer continues to stay in Singapore; and
- The Pioneer continues to require assistance with at least 3 out of 6 Activities of Daily Living (ADLs): (i) showering/bathing; (ii) dressing; (iii) eating; (iv) toileting; (v) transferring from chair to bed or vice versa; and (vi) walking or moving on level surfaces.

For more information on PioneerDAS, please refer to AIC at 1800-650-6060 (Mon to Fri 8.30am – 6pm, Sat 8.30am – 12.30pm) or pioneerDAS@aic.sg

* *Singaporeans who are members of the Pioneer Generation and who meet the criteria to qualify for basic ElderShield payouts will automatically be included in PioneerDAS.*

Part III: 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 ElderShield 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 : | | | | | | | | | — | | |

Account number : | | | | | | | | | | | |

Details of payee (Age above 21 years old)		
Full Name of payee	NRIC number	Contact number
Address		
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)