

Total and Permanent Disability Claim Form (Income Family MicroInsurance Scheme)

Dear claimant

We are sorry to learn of your injury. In order for us to process your claim, please complete this form in **full** and attach the following documents:

- ☐ Total and Permanent Disability Claim Form
- ☐ NRIC or passport of claimant
- ☐ Attending Physician's Statement (APS) (to be completed by attending physician and submitted to us)
- ☐ Medical reports/Hospital discharge summary/Doctor's memos/Investigation reports (CT, MRI, X-rays, histopathology, laboratory), surgical reports and other relevant hospital reports
- ☐ Medically boarded out letter

Claim number (for official use only)

Important notes:

The acceptance of this form is not an admission of liability on the part of NTUC Income.

- (a) Please submit the duly completed claim form together with the supporting documents within six months from date of occurrence. Claims submitted after this deadline will not be accepted.
- (b) Upon receipt of **all** the required documents, we will process your claim and inform you of the outcome as soon as possible. For each of the document listed above, please tick (✓) where applicable. Where not applicable, please indicate as 'N.A'.
- (c) If you need any assistance, please contact our Customer Service Officers at **6788 1122** or email us at csquery@income.com.sg.

Particulars of claimant

Name (as shown in NRIC)	NRIC number
Residential address	
Contact number (Mobile) (Office) (Home)	Email
Is the claimant an undischarged bankrupt? If yes, please provide the bankruptcy number, name and contact details of the case officer representing the Official Assignee.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Details of disability

Cause of disability	Date of disability (dd/mm/yyyy)
Description of disability	
Is there loss of sight? If 'Yes', please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there loss of limbs? If 'Yes', please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Which are the Activities of Daily Living (ADL) that you now cannot perform independently? – feeding, mobility, transferring, washing/bathing, dressing and toileting/continence.	

Particulars of alternative contact person (if any)

Name (as shown in NRIC)	NRIC number
Residential address	Email
Contact number (Mobile) (Office) (Home)	Relationship to claimant

Details of other insurance

Is the insured claiming from any other insurance company or other sources (employer, other medical insurances, Workmen's Compensation Act) in respect of this condition or injury? If 'Yes', please provide the following information.						<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of employer, insurance company etc.	Policy number	Date of issue (dd/mm/yyyy)	Type of plan	Claim amount	Claim notified	Claim paid
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Details of past related claims (if any)

Have you, your spouse, parents, children, brothers or sisters made a claim under the Income Family MicroInsurance Scheme previously? If 'Yes', please provide details of such claim below. Please note that each insured's (under the Income Family MicroInsurance Scheme) family unit is not allowed to submit more than one claim per calendar year. Any claim submitted in breach of this will be rejected.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Declaration

I certify that the information in this form is true and complete and I have not withheld any material information.

For the purposes of policy administration including processing and investigating this claim, and deciding whether NTUC Income is to insure or continue to insure me, my spouse, child, ward and dependant under our 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 NTUC Income and its claims service providers.

b) I authorise NTUC 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 my spouse, child, ward and dependant 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.

Signature of claimant

Date (dd/mm/yyyy)

Confirmation by school (applicable for MOE primary schools only)

This is to confirm that the above-named insured whose child or ward studying in my school is the recipient of the Ministry of Education (MOE) Financial Assistance Scheme from _____ (state month and year).

Name of school representative

Signature of school representative

School's stamp

Date (dd/mm/yyyy)