Income Insurance Limited | UEN: 202135698W
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Attending Medical Practitioner's Statement

Part 1 (To be completed by Insured)

Name of Insured (as shown in NRIC)		NRIC number
Name of next-of-kin (if Insured is below age 21 or deceased)	Relationship to Insured	NRIC number

Declaration and Authorisation
1. I confirm that I have agreed to the "Personal data use statement" provided in the Medical/Accident/Living/Total & Permanent Disability claim form.
2. I agree and authorise:
   (a) Any medical institution or medical practitioner to release to Income any information as requested by Income; and
   (b) Income to release any relevant information concerning me/my child to any medical institution or medical practitioner.

A photocopy of this form is valid as an original copy.

Signature/Thumbprint of Insured/next-of-kin[1] _____ Date (dd/mm/yyyy) _____

[1] Please delete accordingly

Part 2 (To be completed by Doctor)

Name of Insured (as shown in NRIC)	NRIC number

Height of Insured _____ m Weight of Insured _____ kg

The above readings were taken on this date (dd/mm/yyyy) _____ /_____ /_____

1. (a) Are you the Insured's usual doctor?	☐ Yes ☐ No
(b) Over what period do your records extend? Start date (dd/mm/yyyy) _____ /_____ /_____ End date (dd/mm/yyyy) _____ /_____ /_____	
2. What is the diagnosis for the Insured's present illness/injury?	
(a) What is the exact date of diagnosis? (dd/mm/yyyy) _____ /_____ /_____	
(b) Please provide us the name and address of the doctor where the diagnosis was first made.	
(c) Was the Insured informed of the diagnosis? If "Yes", when was he first informed? (dd/mm/yyyy) _____ /_____ /_____	☐ Yes ☐ No
(d) Is the Insured's present illness or condition caused by any other underlying disorders? If "Yes", please give details.	☐ Yes ☐ No
3. (a) Was the condition caused by an accident? If "Yes", please state: Accident date (dd/mm/yyyy) _____ /_____ /_____ Accident time _____	☐ Yes ☐ No
(b) Describe the accident.	

Part 2 (To be completed by Doctor) (continued)

(c) Was the accident reported to the police?	☐ Yes ☐ No
(d) Was the Insured under the influence of alcohol/drugs at the time of accident? If "Yes", please state the blood alcohol content/drug type and quantity consumed.	☐ Yes ☐ No
(e) Is the Insured's condition self-inflicted or as a result of suicide? If "Yes", please provide details.	☐ Yes ☐ No

4. Please provide details of the symptoms presented when you first saw the Insured.

Symptoms presented	Duration of symptoms	Date symptoms first occurred (dd/mm/yyyy)

5. Was the Insured referred to you by another doctor? If "Yes", please provide details. ☐ Yes ☐ No

Name of referring doctor	Name and address of clinic/hospital	Date Insured consulted referring doctor (dd/mm/yyyy)	Reason(s) for the referral

6. Did the Insured see any other doctor(s) besides those indicated above? If "Yes", please provide details. ☐ Yes ☐ No

Name of doctor	Name and address of clinic/hospital	Date Insured consulted doctor (dd/mm/yyyy)	Diagnosis made

7. What were the investigations done to confirm the diagnosis?

Please also enclose copies of all reports used in the management of the Insured's condition(s), e.g. biopsy reports, cytology and histopathology reports, x-rays, CT and MRI scans, other imaging studies, laboratory reports, surgical reports, rehabilitation and occupational therapy report, and other relevant reports.

8. (a) Please provide details of treatment that has been provided (e.g. surgery, chemotherapy, radiotherapy, physiotherapy, etc.).

Type of treatment	Date of treatment (dd/mm/yyyy)	Duration of treatment	Response to treatment

Part 2 (To be completed by Doctor) (continued)

(b) Has the Insured been compliant with the treatment suggested? If "No", please provide details. ☐ Yes ☐ No

(c) Are there plans for other forms of treatment? If "Yes", please provide full details. ☐ Yes ☐ No

Type of treatment	Expected date of treatment (dd/mm/yyyy)	Expected response to treatment

(d) Has the Insured rejected any treatment that would improve his current condition? If "Yes", please provide us the following: ☐ Yes ☐ No

(i) Type(s) of treatment that would improve Insured's condition

(ii) How would the treatment improve Insured's condition and to what extent?

(iii) Why did Insured reject the treatment?

9. What is the prognosis of the Insured's condition? ☐ Improve ☐ Deteriorate ☐ Remain unchanged

(a) Please describe the nature and severity of the Insured's condition.

(b) Is full recovery expected? ☐ Yes ☐ No

If "Yes", please state approximate date (dd/mm/yyyy) _____ /_____ /_____

If "No", please state the extent of recovery and approximate date (dd/mm/yyyy) _____ /_____ /_____

(c) At your last assessment, does the Insured have any deficits pertaining to his general motor functions? If "Yes", please provide details in (i) to (iv). ☐ Yes ☐ No

Date of last assessment (dd/mm/yyyy) _____ /_____ /_____

(i) Range and strength (please indicate power grading of limbs)

(ii) Gait and balance

(iii) Coordination

Part 2 (To be completed by Doctor) (continued)

(iv) Movement

(d) Are there any neurological deficits pertaining to the Insured's sensory functions, or other aspects like hearing, smell, visual? If "Yes", please provide details.	☐ Yes ☐ No

10. (a) Please tick as applicable in relation to the Insured's ability to perform the Activities of Daily Living, whether aided with special equipment or unaided.

Activity	Need someone to help throughout the entire activity	Period which help was required	
		From (dd/mm/yyyy)	To (dd/mm/yyyy)
Washing or bathing Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.	☐ Yes ☐ No		
Dressing Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs, or other surgical appliances.	☐ Yes ☐ No		
Feeding Ability to feed oneself once food has been prepared and made available.	☐ Yes ☐ No		
Toileting Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.	☐ Yes ☐ No		
Transferring Ability to move from a bed to an upright chair or wheelchair and vice versa.	☐ Yes ☐ No		
Mobility Ability to move indoors from room to room on level surfaces.	☐ Yes ☐ No		

(b) Is the Insured confined to a home/hospital/or other institution which provides continuous care and medical attention? If "Yes", please provide name and address of this institution, and period(s) of confinement (dd/mm/yyyy).	☐ Yes ☐ No

11. What was the Insured's occupation before his disability?

(a) What was the nature of his duties?

(b) Does the Insured's disability prevent him from performing the above listed duties? If "Yes", please state why.	☐ Yes ☐ No
12. (a) Has the Insured returned to his usual occupation?	☐ Yes ☐ No

(b) If "No", would the Insured be able to return to his usual occupation at a later date?

☐ Not able to determine presently (Go straight to Question 14)

☐ Yes – Expected date of return to his usual occupation is (dd/mm/yyyy) _____ /_____ /_____

☐ No – Not possible to return to usual occupation even at a later date

Part 2 (To be completed by Doctor) (continued)

13. If the Insured cannot return to his usual occupation even at a later date because of his condition, is there any other suitable occupation(s), including sedentary or simpler or desk bound types of occupation (e.g. data entry job, etc.) that he can consider in the future?

☐ Yes Examples of such occupation(s) are: _____
Expected date when his condition allows him to engage in these occupation(s) is:

(dd/mm/yyyy) _____ /_____ /_____

☐ No The Insured is unable to take part in <u>any paid work for the rest of his life.</u>
Please provide us with reason (s) for your answer.
Reason (s):

_____

_____

_____

_____

_____

Please state the date when the Insured was considered not able to take part in any paid work for the rest of his life.

(dd/mm/yyyy) _____ /_____ /_____

14. If the extent of the Insured's disability cannot be determined at this moment, when would be an appropriate date to assess it?

(dd/mm/yyyy) _____ /_____ /_____

15. Please tick (✓) and answer all applicable sections. Where not applicable, please indicate 'N.A.'

(a) Total and permanent loss of sight
The loss must be permanent and irreversible, even with the use of visual aids.

☐ Right eye

Date of total and permanent loss of sight (dd/mm/yyyy)		Date of last review (dd/mm/yyyy)	
Visual acuity		Visual acuity	
Visual field		Visual field	

☐ Left eye

Date of total and permanent loss of sight (dd/mm/yyyy)		Date of last review (dd/mm/yyyy)	
Visual acuity		Visual acuity	
Visual field		Visual field	

Please describe the nature and cause of total and permanent loss of sight.

_____

_____

_____

_____

_____

Part 2 (To be completed by Doctor) (continued)

(b) Severance of limbs/total loss of use of limbs

☐ Severance of upper limbs

	Left upper limb	Date (dd/mm/yyyy)	Right upper limb	Date (dd/mm/yyyy)
Severance at or above wrist	☐ Yes ☐ No		☐ Yes ☐ No	
Severance at or above elbow	☐ Yes ☐ No		☐ Yes ☐ No	
Others (please specify: _____)	☐ Yes ☐ No		☐ Yes ☐ No	

Please describe the nature and cause of severance.

_____

_____

☐ Severance of lower limbs

	Left lower limb	Date (dd/mm/yyyy)	Right lower limb	Date (dd/mm/yyyy)
Severance at or above ankle	☐ Yes ☐ No		☐ Yes ☐ No	
Severance at or above knee	☐ Yes ☐ No		☐ Yes ☐ No	
Others (please specify: _____)	☐ Yes ☐ No		☐ Yes ☐ No	

Please describe the nature and cause of severance.

_____

_____

☐ Total loss of use (defined as total and permanent loss of physical function)

	Date of commencement of loss of use (dd/mm/yyyy)	Please describe the nature and cause of total loss of use
Left upper limb		
Left lower limb		
Right upper limb		
Right lower limb		

Please describe the nature and cause of severance.

_____

_____

Part 2 (To be completed by Doctor) (continued)

16. (a) Please describe the Insured's mental and cognitive abilities.

(b) Is the Insured mentally incapacitated in accordance to the Mental Capacity Act? ☐ Yes ☐ No

(c) If "Yes" to Question 16b above, please state the date when the mental incapacity started.

Date of last assessment (dd/mm/yyyy) _____ /_____ /_____

17. Is the Insured suffering or has suffered from any other disease or ailment? If "Yes", please provide full details. ☐ Yes ☐ No

Name of doctor	Name and address of clinic/hospital	Date Insured consulted doctor (dd/mm/yyyy)	Diagnosis made

18. Is the Insured terminally ill, i.e. death is expected within 12 months? If "Yes", please provide details on the basis of your evaluation. ☐ Yes ☐ No

Please indicate the date on which the Insured is assessed to be terminally ill.

(dd/mm/yyyy) _____ /_____ /_____

19. Please provide us with any other information that will be helpful in the assessment of this claim.

_____ _____

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

_____ _____

Name and qualification (printed) | Address and official stamp of clinic/hospital

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NTUC GIFT
Total/Partial and Permanent Disability Claim Form

Dear Claimant

We are sorry to learn of your disability. In order for us to assess your claim, please complete this form in FULL and attach the required documents.

Important notes

(a) All items must be duly completed to avoid delay to the claim process. Please indicate as "N.A." if not applicable.

(b) Upon receipt of ALL the required documents, we will assess your claim and inform you of the outcome as soon as possible. Please allow approximately 4 - 6 weeks for claim assessment, subject to submission of all required documents.

(c) The acceptance of this form is NOT an admission of liability on the part of Income. Any documentary proof or report required by Income shall be furnished at the expense of the Claimant. To avoid delay to the claim process, please submit the duly completed claim form together with the supporting documents **within 90 days from date of occurrence**.

(d) **Please submit all claim documents through your respective union (for Ordinary Branch) or NTUC Membership Dept (for General Branch/UClub/UAssociate).**

(e) 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.

Information on member

Full Name of member (as shown in NRIC, FIN or passport)	NRIC, passport or FIN number	Gender ☐ Male ☐ Female
Mailing address	Nationality	Country of residence
Contact number (Mobile) (Office) (Home)	Email	

Information on insured person

Insured person is:
☐ Member ☐ Member's Spouse

Full Name of insured person (as shown in NRIC, FIN or passport)	NRIC, passport or FIN number	Nationality	Country of residence

Details of occupation

	Before Disability	**After Disability**
Occupation		
Name of employer		
List exact duties performed at work (If you are not working, please provide a list of daily activities before and after disability)		

Income reserves the right to request for documentary evidence related to **Details of occupation**.

Details of disability

Disability suffered due to:

☐ Illness

Diagnosis _____ Date symptoms started _____ (dd/mm/yyyy)

☐ Accident

Date of accident _____ (dd/mm/yyyy) Time of accident _____

Place of accident _____

Did the insured report for work on date of accident? ☐ Yes ☐ No

Did the accident occur while the insured was at work? ☐ Yes ☐ No

Current Employment status ☐ Employed ☐ Unemployed	Date last worked (dd/mm/yyyy)
The insured is currently confined to ☐ bed ☐ house ☐ hospital ☐ N.A.	Date insured returned or expect to return to work (dd/mm/yyyy)

Describe in detail the disability suffered

Details of doctor(s) consulted or hospital admission(s) for this disability

Name of doctor	Name and address of clinic or hospital	Date(s) of consultation (dd/mm/yyyy)	Date(s) of admission (dd/mm/yyyy)

Details of your regular or company doctor or any other doctor(s) consulted for any other medical conditions

Name of doctor	Name and address of clinic or hospital	Date(s) of consultation (dd/mm/yyyy)	Reason(s) for consultation

Other claims

Is the Member or spouse claiming from any other insurance company(ies) or other sources (employer, other medical insurances, Work Injury Compensation Act) in respect of this condition or injury? If "Yes", please provide the following information. ☐ Yes ☐ No

Name of employer, insurance company etc.	Policy number	Date of issue	Type of plan	Claim amount	Claim notified (Yes or no)	Claim paid (Yes or no)

Other information

Has the claimant been bankrupt or insolvent or has executed any deed or transfer for the benefit of creditors since becoming interested in the policy? If "Yes", please provide details.

Policyholder ☐ Yes ☐ No Details: _____

Assignee ☐ Yes ☐ No Details: _____

Donee/
Court Appointed Deputy ☐ Yes ☐ No Details: _____

Insured ☐ Yes ☐ No Details: _____

The following documents are attached to this application [Please tick (√) if applicable]:

- ☐ Total/Partial and Permanent Disability claim form (to be completed by member/spouse/next of kin and verified/endorsed by the respective union)
- ☐ Copy of NRIC or passport of insured member and spouse (if claiming for disability of spouse)
- ☐ Attending Medical Practitioner's Statement (AMPS) (to be completed by attending doctor and submitted to us)
- ☐ Medically boarded out letter (where applicable)
- ☐ Newspaper cutting and Outcome of police investigation report (if disability was due to accident)
- ☐ Marriage Certificate and the screenshot from SingPass ->My Profile-> Family showing the claimant's marital information if claiming for disability of spouse
- ☐ Employer's letter to certify the working hours of member on the date of accident

Payee's details

Name of payee (as shown in the bank account)	NRIC, FIN or Passport number (as shown in the bank account)	Relationship to the insured	Nationality	Country of residence

Payment option:

☐ PayNow

- PayNow account must be registered with NRIC, FIN or UEN.
- PayNow account registered with mobile number or Trust Bank will not be applicable.
  (Note: You may register or add your Singapore NRIC/FIN to the PayNow account via the "Manage PayNow" in your internet banking or mobile banking application.)

☐ Direct Credit

Bank name: _____ Account number: _____

- It must be a Singapore bank account denominated in Singapore Dollar.
- It is compulsory to submit a copy of bank book/statement for verification purpose.

Personal data use statement (A photocopy of this authorisation is valid as an original copy)

By providing the information and submitting this application or transaction, I/we consent and agree to Income Insurance Limited ("Income Insurance"), its representatives, agents, relevant third parties, Income Insurance's appointed insurance intermediaries and their respective third party service providers and representatives (collectively "Income Insurance Parties") (referred to in Income Insurance's Privacy Policy at http://www.income.com.sg/privacy-policy) to collect, use, and disclose any personal data in this form or obtained from other sources, including existing personal data provided and any future updates, (collectively "personal data") for the purposes of processing and administering my/our insurance application or transaction, providing me/us with financial advice and/or recommendation on products and services, managing my/our relationship and policies with Income Insurance including sending me/us corporate communications and notices on updates and servicing, research and data analytics, and in the manner and for the purposes described in Income Insurance's Privacy Policy.

Where the personal data of another person(s) (for example, personal data of my family, employee, payee/payer or beneficiary) is provided by me/us or from other sources to Income Insurance Parties, I/we represent and warrant that:

- I/we have obtained their consent for the collection, disclosure and use of their personal data; and
- I am/we are authorised to give any authorisation, approval and consent on their behalf to collect, use or disclose, their personal data,

for the purposes as set out in this Personal Data Use Statement.

For the purpose of this application and any claim in connection with my/our policy(ies) with Income Insurance, 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 Insurance any medical or relevant information to do with me or the insured;
b) Income Insurance 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; and
c) Income Insurance or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests for Income Insurance 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 Insurance.

When submitting a claim for an insurance policy, I/we consent and agree that the personal data will also include any subsequent information collected on health or any information that is necessary for Income Insurance to decide whether to pay the claim, such as test results, medical examination results, and health records from medical sources such as medical examiners or laboratories.

I/We authorise, consent and agree to the following:

- Income Insurance Parties to collect from and/or disclose to the group policyholder, the personal data for all the relevant purposes listed above and in Income Insurance's Privacy Policy including to respond to enquiries from the group policyholder for the purposes of this application and policy servicing matters, including confirmation of eligibility for the cover; and
- The group policyholder to disclose the personal data to Income Insurance Parties for all the relevant purposes listed above and in Income Insurance's Privacy Policy.

Please refer to Income Insurance'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 collection, use and disclosure of my personal data as stated in the 'Personal Data Use Statement'(PDUS) above.

For the purposes of policy administration including processing and investigating this claim, and deciding whether Income Insurance 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 Insurance and/or its claims service providers.

b. I authorise Income Insurance 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 confirm that all documents submitted to Income Insurance including bills and invoices are copy of the original documents and I am aware that I am required to retain all original documents for a period of 6 months from claim submission date for verification by Income Insurance when required. I am aware that Income Insurance may reject my claim should it discover that the document(s) that I have submitted is not a copy of the original document(s).

I confirm that I have paid in full all the bill(s)/invoice(s) that I have submitted to Income Insurance for reimbursement and I have not made any claim and will not make any claim from any other source for the same bill(s)/invoice(s). If I have made a claim from other source, I agree that I will provide a copy of the settlement agreement between me and such other source. I am aware that Income Insurance will not reimburse me if I have received a full reimbursement from any other source. If I do not receive full reimbursement from other source, I am aware and understand that Income Insurance will only reimburse me the balance of the bill/invoice that has not been paid to me by other source. In the event Income Insurance has made a reimbursement to me and I have claimed from other sources and be reimbursed for more than what I incurred in total, I agree that Income Insurance has the right to recover any payment made by Income Insurance to me.

I agree that a photocopy or electronic version of this authorisation shall be as valid as the original.

Signature of member	Date (dd/mm/yyyy)
Signature of spouse (To be completed only if claim is for spouse)	Date (dd/mm/yyyy)

For Official Use Only

To be completed by Union or Association		
Name of current ☐ Union ☐ Association	Date joined current Union or Association (dd/mm/yyyy)	
Name of first ☐ Union ☐ Association (if different from above)	Date joined first Union or Association (dd/mm/yyyy)	Continuous membership tenure _____ years _____ months
Membership type ☐ Ordinary branch ☐ General branch ☐ UClub ☐ UAssociate	Date of birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female

To be completed if member is/was a Union or Association leader (registered with RTU or LDIS)

Position in Union or Association	Served as Union or Association leader From (dd/mm/yyyy) _____ To (dd/mm/yyyy) _____

Note: Leaders must be holding office as at the date of occurrence.

For members aged 65 years and above, please confirm whether member is covered under NTUC GIFT extension. ☐ Yes ☐ No

We certify that the information in this form is true and complete, that the above member/member's spouse* was eligible for the NTUC GIFT plan and the member was in our membership roll at the date of disability of member/member's spouse*.

_____ _____

Name of authorised person | Signature of authorised person

Designation: President/General Secretary/Executive Secretary/
Treasurer [for OB members]/
Assistant Director/Deputy Director/Director,
NTUC Membership Dept [for GB/UClub/UAssociate members]*

_____ _____

Date (dd/mm/yyyy) | Union/Association stamp

* Delete where applicable

Instruction to Unions/Associations:

Please check that all required documents are attached to the claim form and email to **groupclaim@income.com.sg**.