NTUC Income Insurance Co-operative Limited
Income Centre 75 Bras Basah Road Singapore 189557
Tel: 6332 1133 · Fax: 6338 1500
Email: csquery@income.com.sg · Website: www.income.com.sg
an NTUC Social Enterprise

NTUC Gift
Total and Permanent Disability Claim Form

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 required documents.

Important notes

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

(b) Upon receipt of ALL the required documents, we will process your claim and inform you of the outcome as soon as possible. Please allow approximately 4 - 6 weeks for claim processing, 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 in processing your claim, please submit the duly completed claim form together with the supporting documents **within 90 days from date of ocurrence**.

(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

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

Information on insured person

Please tick accordingly:

☐ Member ☐ Spouse (below 65 years old) – please attach Marriage Certificate as proof of relationship

Name (as shown in NRIC, passport or FIN):

Details of occupation

	Before Disability	After Disability
Occupation		
Name of employer		
Average monthly income		
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**.

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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 insured 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. ☐ Yes ☐ No

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

- ☐ Total and Permanent Disability claim form (to be completed by claimant and verified/endorsed by the respective union)
- ☐ NRIC or relevant identification documents (e.g. passport, birth certificate of claimant)
- ☐ Attending Medical Practitioner's Statement (AMPS) (to be completed by attending doctor and submitted to us)
- ☐ Medical reports/laboratory reports/hospital discharge summary
- ☐ Medically boarded out letter (where applicable)
- ☐ Newspaper cutting and police/accident report (if Total and Permanent Disability was due to accident)

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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.

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) carry out membership or information checks;
(c) communicate on purposes relating to this transaction;
(d) decide whether to insure or continue to insure you and your insured persons;
(e) provide ongoing services and respond to your inquiries or instructions;
(f) make or obtain payments from the relevant institutions relating to this transaction;
(g) investigate and settle claims;
(h) detect and prevent fraud, unlawful or improper activities;
(i) reinsure risks and for reinsurance administration; and
(j) 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) medical professionals and institutions;
(b) insurers and reinsurers;
(c) 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;
(d) debt collection agencies in the event of but not limited to, overpayment of claims;
(e) dispute resolution parties;
(f) parties that assist us to investigate, administer and adjudicate claims;
(g) financial institutions to assist us in settlement of this claim;
(h) industry associations in the event of but not limited to, dispute resolution; and
(i) regulators, law enforcement and government agencies.

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

You may refuse or 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. But if you withdraw your consent for us to use your personal data for your insurance matters, 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 will require you to surrender or terminate all your policies with us.

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 withdraw your consent, 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

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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 collection 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 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.

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

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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 mail it to the following address:

Attn: **Group Business**
NTUC Income Insurance Co-operative Limited
Income Centre
75 Bras Basah Road
Singapore 189557