income made yours

Income Insurance Limited | UEN: 202135698W
Income Centre 75 Bras Basah Road Singapore 189557
Tel: 6788 1777 · Fax: 6338 1500
Enquiries: income.com.sg/enquiry

Scan to update your particulars

Claim form for Child Illness Rider

Please submit your claim through your insurance advisor OR via email to us at healthcare@income.com.sg

Important notes

1. The acceptance of this form is **NOT** an admission of liability on the part of Income Insurance.
2. Medical report must be given at the expense of the policyholder or insured.
3. Please ensure that both Section 1 and Section 2 of the claim form are completed before you submit the claim.
4. **Before the submission, do ensure your contact details (address, email and contact numbers) with us are updated. Please scan the QR code on page 1 of this form to update your particulars. We will correspond with you based on your contact details registered with us. Please note that the contact details provided in this form will NOT be updated in our records.**

Section 1 – To be completed by policyholder

Particulars of policyholder and insured

Full name of insured (as shown in NRIC/FIN card/Birth Certificate)	
NRIC/FIN/Birth Certificate number of insured	Policy number
Full name of policyholder (as shown in NRIC/FIN card/Passport)	
NRIC/FIN/Passport number of policyholder	Relationship to insured

Record of medical consultations

1. Please provide details of any other doctors or specialists the insured has consulted in connection with this illness or injury

a) Name and address of hospital or clinic	b) Date of first consultation

2. Name and address of insured's regular doctor

3. Please tick the condition which you are claiming for.

- ☐ Severe asthma
- ☐ Bone marrow transplant
- ☐ Still's disease
- ☐ Kawasaki disease
- ☐ Mental retardation due to sickness, injury or accident
- ☐ Leukaemia
- ☐ Insulin-dependent diabetes mellitus
- ☐ Rheumatic disease with valvular impairment
- ☐ Haemophilia
- ☐ Accidental fracture of skull, spine, pelvis or femur

Payment method

Payment (if any) will be credited into your bank account (Please submit a copy of your bank book/statement for account verification. It must show the bank name, bank account number and full names of all bank account holders. Please circle the account for crediting if your statement shows more than 1 bank account.)

Notes:

1. *We reserve the right to request for a copy of your bank book or statement for account verification before payment at any point in time where we deem necessary.*
2. *If there is a change of bank account, please submit to us a copy of your new bank book or statement for account verification and for us to update your bank account record with us.*

Personal Data Use Statement

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 (referred to in Income Insurance's Privacy Policy at income.com.sg/privacy-policy), Income Insurance's appointed insurance intermediaries and their respective third party service providers and representatives (collectively "Income Insurance Parties") to collect, use, and disclose any personal data in this form or obtained from other sources, including existing personal data provided, any future updates and subsequent information on my/our health or financial situation (collectively "personal data") for the purposes of processing and administering my/our insurance application or transaction, managing my/our relationship and policies with Income Insurance including providing me/us with financial advice/ financial planning services, sending me/us corporate communication and information on products and/or services related to my/our ongoing relationship with Income Insurance, conducting consumer profiling/data analytic/research, which includes data matching based on personal data collected by Income Insurance, its affiliates, business partners and/or NTUC Enterprise group of social enterprises ("NE Group") where required for Income Insurance, its affiliates, business partners and/or NE Group, to develop, improve and/or customise their products/services and/or to provide you with their respective products/ services, and in the manner and for other purposes described in Income Insurance's Privacy Policy.

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

- I/we have obtained their consent for the collection, use and disclosure of their personal data; and
- I am/we are authorised to give any authorisation and approval on their behalf, for the purposes as set out in this Personal Data Use Statement.

I/We agree that if my/our policy(ies) premiums are paid by third-party payor(s), I/we consent to the use and disclosure of my/our and relevant policy(ies) information including the insured's name, by Income Insurance to such third-party payor(s) for the purposes of processing and/or administering premiums payments for my/our policy(ies).

Please refer to Income Insurance's Privacy Policy (income.com.sg/privacy-policy) for more information, including access and correction to personal data and consent withdrawal. I/We agree and understand that Income Insurance's Privacy Policy available on its website may be amended, supplemented and/or substituted by Income Insurance from time to time.

Declaration and authorisation

1. I cannot alter any of the wordings in this form. Any attempt to do so will have no effect.
2. I declare that the answers given in this form are true, correct and complete. I accept full responsibility for them, whether written by me or by anyone else on my behalf. I have not withheld any information.
3. 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. I further confirm on the representation and warranty made in the PDUS.
4. I confirm that I am authorised to disclose information (including personal information) about the insured if this claim is made on behalf of them.
5. For the purpose of administering and processing my claim, I authorise, consent and agree to:
   a. The medical source, insurance office, reinsurer, organisation to release to Income Insurance any medical or relevant information to do with me or the insured;
   b. Income Insurance and its relevant third parties stated in Income Insurance's Privacy Policy to collect from, use 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 assess this claim.

   I agree that a copy of the authorisation in this form is valid and binding as an original copy.
6. I understand that I must give Income Insurance all documents, authorisations or information required by Income Insurance to assess the claim. If I fail to co-operate with Income Insurance in administering and processing the claim, I am aware that the assessment of the claim may be delayed or Income Insurance may reject the claim.
7. I agree that if I or any #Relevant Person is found to be a +Prohibited Person:
   - if any policy is issued, you are entitled to end this policy, not pay any benefit or not allow any transaction, such as surrender and assignment, to be carried out under this policy. You will not refund any unutilised premium when this policy is ended.

   Your decision in every respect of the above will be final.

   I will inform you immediately if there is any change in my or any Relevant Person's identity, status or identity documents.

   [#] *<u>Relevant Person</u> includes insured, trustee, settlor, beneficiary, assignee, nominee, payee, mortgagee, financier of this application/policy, and in relation to an entity, its director, partner, manager, person having executive authority, authorised signatory, shareholder or beneficial owner.*

   [+] *<u>Prohibited Person</u> means a person or entity who is, or who is ^Related to a person or entity:*
   - *subject to laws, regulations or sanctions administered by any inter-government, government, regulatory or law enforcement authorities of any country, which will prohibit or restrict you from providing insurance or carrying out any transaction under this policy, or*
   - *who is involved in any terrorist or illegal activities or placed on sanctions listing or issued with freezing order.*

   [^] *<u>Related</u> includes relationships such as parent, step-parent, child, step-child, adopted child, spouse, sibling, step-sibling, adopted sibling, parent-in-law, child-in-law, sibling-in-law, cousin, uncle, aunt, grandparents, niece, nephew, grandchild, employee, employer, associate, parent company, subsidiary and shareholder.*
8. I agree that this form may be signed by electronic or digital signature, whether encrypted or not, which will be considered as an original signature for all purposes and shall have the same force and effect as an original signature. Electronic signature may include electronically scanned and transmitted versions (e.g. via pdf) of an original signature.
9. I confirm that the insured has an eligible valid pass. I am aware that all benefits under IncomeShield will end when the insured, who is a foreigner, no longer has an eligible valid pass, and Income Insurance will not be legally responsible for any further payment under the IncomeShield policy.
10. I agree to refund in full the monies which is paid by mistake or which I am not entitled to receive to Income Insurance immediately upon Income Insurance's request or once I found out on such mistake or wrong payment.
11. I understand and agree that once Income Insurance makes payment for a claim under this form to me (including any subsequent payment arising from this claim), Income insurance's liability for such claim will be fully released and discharged accordingly.

Full name (as shown in NRIC/FIN card/Passport) and signature of policyholder (individual)	NRIC/FIN/Passport number	Date signed (dd/mm/yyyy)

Please ensure that "Attending Physician's Statement for Child Illness Rider" on the next page is completed.

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Attending Physician's Statement for Child Illness Rider

Section 2 – To be completed by the attending doctor

Part 1: General Information

1. Are you the patient's usual medical doctor? If 'Yes', over what period do your records extend to?

2. When did the patient first consult you for this condition?

3. When you first saw the patient, what were the symptoms presented and how long did they last? Please state the date that the symptoms began.

4. In your opinion, how long has the patient been having these symptoms? Please provide reasons.

5. Did the patient consult any other doctors for these symptoms before consulting you?

6. What is the diagnosis? Please provide full details of the diagnosis, including the date of diagnosis.

7. When did the patient or the parent first become aware of the condition?

Part 2: Details of child's illness (Please fill in the appropriate section.)

1. Severe asthma

	Question		
a)	Has there been a history of status asthmaticus within the past two years?	☐ Yes	☐ No
b)	Did the patient exhibit significant and continuous reduction in exercise tolerance?	☐ Yes	☐ No
c)	Were there chest deformities resulting from chronic hyperinflation?	☐ Yes	☐ No
d)	Was there a need for medically prescribed oxygen therapy at home?	☐ Yes	☐ No
e)	Was the patient on continuous daily use of oral corticosteriods (for at least six months)?	☐ Yes	☐ No

2. Leukaemia

a) Please provide details of any chemotherapy or radiotherapy treatment provided, including the dates and type of treatment provided.

b) Please provide details of all investigations performed.

3. Bone-marrow transplant

a) What is the underlying condition for which the patient needs a bone-marrow transplant?

	Question		
b)	Has the patient had a bone-marrow transplant? If 'Yes', please provide the date of the transplant and the name of the hospital where the transplant was performed.	☐ Yes	☐ No
c)	If the patient has not had a bone-marrow transplant, has the patient been confirmed as accepted on the official waiting list of the medical or health authorities in Singapore for a transplant, as a recipient? If 'Yes', please provide the date and the details where the patient was placed on a waiting list.	☐ Yes	☐ No

4. Insulin-dependent diabetes mellitus

a) Was the presence of severe diabetes mellitus characterised by:
   i. loss of plasma insulin levels; ☐ Yes ☐ No
   ii. episodic ketoacidosis? ☐ Yes ☐ No

b) Please give details if the patient is insulin-dependent and enclose a copy of the blood and urine test results.

c) Was there evidence of decreasing C-peptide? Please provide details.

d) Please give details of all investigations done and treatment prescribed.

5. Rheumatic disease with valvular impairment

a) Was there impairment or damage to one or more heart valves and was this supported by an echocardiogram? ☐ Yes ☐ No

b) Was there evidence of a history of rheumatic fever? ☐ Yes ☐ No

c) Please give details of any group-A streptococcus infection with supporting evidence.

d) Please provide details of all investigations carried out and enclose copies of the results of the echocardiogram and laboratory investigations.

6. Kawasaki disease

a) Was there cardiac involvement with dilation or aneurysm formation in coronary arteries which lasted at least six months after the initial acute episode? ☐ Yes ☐ No
If 'Yes', please provide details including the date it began and how long the coronary artery dilation or aneurysm formation lasted.
Please enclose copies of investigations carried out confirming this.

7. Haemophilia

a) Was the condition mild, moderate or severe?

b) Was the clotting factor VIII less than 1%? ☐ Yes ☐ No

c) Was the clotting factor IX less than 1%? ☐ Yes ☐ No

8. Still's disease

a) Does the patient show the features of Still's disease? Please provide details.

b) Does the patient need a knee or hip replacement? If 'Yes', please provide details. ☐ Yes ☐ No

c) Please enclose copies of all laboratory test results, including blood-test results.

9. Mental retardation due to sickness, injury or accident

a) Was the condition caused by sickness, injury or accident? ☐ Yes ☐ No

b) If the condition was due to injury or accident:
   i. please provide the date of the accident and give details of the circumstances leading to the injury or accident.

   ii. Were there any contributory factors leading to the injury or accident? (For example, the influence of alcohol or drugs, self-inflicted injury, etc.)

c)	If the condition was due to sickness: i. please provide the date the sickness began.		
	ii. what were the underlying conditions?		
d)	Has the condition continued without interruption for at least six months in a row after diagnosis?	☐ Yes	☐ No
e)	Was the condition caused by congenital illness or condition?	☐ Yes	☐ No

10. Accidental fracture of the skull, spine, pelvis or femur

a)	Was the patient's condition due to an accident?	☐ Yes	☐ No
b)	Did the accident result in a fracture of the skull, spine, pelvis or femur?	☐ Yes	☐ No
c)	Did the fracture involve the insured staying in hospital for treatment?	☐ Yes	☐ No
d)	Was the patient's condition a hairline fracture which does not involve the periosteum or the articular surface?	☐ Yes	☐ No
e)	Was the patient's condition due to self-inflicted injuries?	☐ Yes	☐ No
f)	Was the patient's condition caused by drug or alcohol abuse or misuse?	☐ Yes	☐ No
g)	Please provide details of the accident.		
	i. Date of accident (dd/mm/yyyy):		
	ii. Time of accident		
	iii. Place of accident		
	iii. Describe the extent of the injury and give details of the anatomical site involved.		
h)	Please enclose copies of the X-ray.		

Other useful information

1. Please provide us with any other information that will be helpful in assessing this claim.

2. We would appreciate it if you could enclose copies of all relevant diagnostic and laboratory test results.

Signature of doctor or medical officer-in-charge

Date (dd/mm/yyyy)

Name (in block letters)

Address and official stamp of hospital or clinic