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Enquiries: income.com.sg/enquiry

Attending Medical Practitioner's Statement
Cancer Drug Treatment Claim
IncomeShield Plan

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

Important notes

1. This form is applicable for Non-Integrated IncomeShield Plan claiming under the Outpatient Cancer Drug Treatment claims where the hospital/ licensed medical centre or clinic is unable to electronically file through the system set up by MOH.
2. This form is not applicable for Class F cancer drug (Refer to www.lia.org.sg for more details)
3. Please ensure all cancer drug expenses incurred in the same month are submitted to us in the same submission. (ie. If you have multiple claims to be submitted in the same month, please collate all bills and supporting documents, and only submit them to us in one submission at the end of the month) This is to ensure we assess your claim in accordance with the policy terms and conditions.
4. This form must be duly completed to avoid delay in claim processing. Please indicate as "N.A." if not applicable.
5. Any documentary proof or report required by Income Insurance shall be furnished at the expense of the policyholder or claimant.
6. The acceptance of this form is NOT an admission of liability on the part of Income Insurance.

Part 1 (To be completed by Insured or Policyholder)

Full name of insured (as shown in NRIC/FIN card/Passport/Birth certificate)	NRIC/FIN/Passport/Birth certificate number of insured	Policy number

Full name of policyholder (as shown in NRIC/FIN card/Passport) if different from insured	NRIC/FIN/Passport/Birth certificate number of policyholder (if different from insured)

Other insurances

Is the insured covered for medical expenses by any other insurance company(ies), his employer or any other parties? If "Yes", please state details below.	☐ Yes ☐ No
Is the insured claiming from any other insurance company(ies) or other sources (employer, other medical insurances, Workmen's Compensation Act) in respect of this condition/injury? If "Yes", please provide the following information.	☐ Yes ☐ No

Name of employer, insurance company etc.	Policy number	Date of issue (dd/mm/yyyy)	Type of plan	Claim amount	Claim notified (Yes/No)	Claim paid (Yes/No)

For medical claims, please provide a copy of the respective settlement letter from the other insurance company or other sources.

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 https://www.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/insured name(s) and relevant policy(ies) information 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 (https://www.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, 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, 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 confirm that all copies of the claim documents that I have submitted to Income Insurance are copies of the original documents and I agree to retain all original documents for a period of 6 months from claim submission date for Income Insurance to verify its authenticity.
7. I am aware that Income Insurance may reject any claim if any copy submitted is not a copy of the original document and may recover any payment made to me.
8. 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 nor will I make any claim against any other source for the same bill(s)/invoice(s).
9. If I have made a claim from other source,
   (a) I agree that I will provide a copy of any document requested by Income Insurance of the payment received by me;
   (b) I am aware that Income Insurance will not reimburse me if I have been fully reimbursed by such source;
   (c) I am aware that Income Insurance may only reimburse me up to the remaining balance of the unpaid bill/invoice I have been partially reimbursed by such source;
   (d) I undertake to refund on demand any payment made by Income Insurance to me which exceeds what I have incurred in total.
10. 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 administrating and processing the claim, I am aware that the assessment of the claim may be delayed or Income Insurance may reject the claim.
11. 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.

    [#] *Relevant Person 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.*

    [+] *Prohibited Person 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.*

    [^] *Related 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.*
12. 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 (eg. via PDF) of an original signature.
13. I confirm that the insured has an eligible valid pass i.e. a valid pass with a foreign identification number (FIN) recognised by the Immigration and Checkpoints Authority of Singapore (ICA). 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.

Declaration and authorisation (continued)

14. 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.
15. 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/thumbprint of **policyholder** (individual)	NRIC/FIN/Passport number	Date signed (dd/mm/yyyy)
Full name (as shown in NRIC/FIN card/Passport) and signature/thumbprint of **insured** who is 21 years old or above (if different from policyholder)	NRIC/FIN/Passport number	Date signed (dd/mm/yyyy)

Attending Medical Practitioner's Statement
Part 2 (To be completed by Doctor)

Full name of insured (as shown in NRIC/FIN card/Passport/Birth certificate)	NRIC/FIN/Passport/Birth certificate number
Diagnosis	**Date of Diagnosis**

[Please use Annex A of the Attending Medical Practitioner's Statement if there are more than one (1) cancer drug used]

Cancer Drug administered

1. Details of Cancer Drug

Name	
Active ingredient	
Brand	

(a) Is this cancer drug on CDL (MOH)? ☐ Yes ☐ No

If "Yes", please provide the clinical indication

Example:

CI00213	For peripheral T-cell lymphoma in adults who have received >=1 prior therapy.

Indication code	
Clinical indication	

(b) Is there also a cancer drug claim concurrently being electronically filed to IncomeShield? ☐ Yes ☐ No

If "Yes", please provide Hospital Registration No. (HRN) of the e-filed claim:

Note:

- If there is a CDL treatment (paired with a drug) combined and used at the same time with another CDL/non-CDL treatment, and this combination of drugs is not claimable under MSHL and Integrated Plans, please select the indication code CI00000 "Others" and do not select the indication code paired with the drug on the CDL.
- CDL treatments with "For Cancer Treatment" can continue to be submitted under indication code CI99999 "For Cancer Treatment".
- This note is subject to further updates from MOH.

Please complete this section if the cancer drug is not on the CDL (MOH).

2. Classification of Non-CDL

(a) What is the Non-CDL Classification of the cancer drug treatment being administered? Tick accordingly

☐ Class A	☐ Class B	☐ Class C	☐ Class D	☐ Class E	☐ Class F

Please advise the indication to provide why this cancer drug treatment falls under this classification.

(b) Has this cancer drug been approved for the patient's indication by any of the following bodies? Please tick at least one.

☐ HSA
☐ US FDA
☐ EMA
☐ TGA Australia
☐ Health Canada
☐ UK MHRA
☐ Others (Pls specify): _____
☐ None known

Attending Medical Practitioner's Statement
Part 2 (To be completed by Doctor) (continued)

(c) If it is approved by a regulatory body, please specify the indication.	☐ Yes ☐ No
(d) Please provide weblink for any medical literature or international guidelines OR provide hardcopy with highlights to support the Non-CDL Classification.	☐ Yes ☐ No
(e) If 2b) is "None Known", please advise if there is any Clinical Guidelines under NCCN and ESMO for the cancer drug use. If "Yes", please provide weblink for the relevant NCCN/ESMO guideline and provide the page number corresponding to the insured's treatment OR provide a hardcopy with highlights.	☐ Yes ☐ No
(f) Was the treatment brought in via Special Access Route (SAR) under Health Science Authority of Singapore (HSA)?	☐ Yes ☐ No

3. Other information of the Cancer Drug

(a) Dosage/Quantity prescribed	
(b) Date of treatment/Start date (mm/yyyy)	
(c) What is the number of treatment(s) required in the same month?	

4. Please provide us with a copy of the histopathology report pertaining to the cancer condition.

5. 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

Annex A - Attending Medical Practitioner's Statement
Part 2 (To be completed by Doctor)

Full name of insured (as shown in NRIC/FIN card/Passport/Birth certificate)	NRIC/FIN/Passport/Birth certificate number
Diagnosis	**Date of Diagnosis**

[Please use Annex A of the Attending Medical Practitioner's Statement if there are more than one (1) cancer drug used]

Cancer Drug administered

1. Details of Cancer Drug

Name	
Active ingredient	
Brand	

(a) Is this cancer drug on CDL (MOH)? ☐ Yes ☐ No

If "Yes", please provide the clinical indication

Example:

CI00213	For peripheral T-cell lymphoma in adults who have received >=1 prior therapy.

Indication code	
Clinical indication	

(b) Is there also a cancer drug claim concurrently being electronically filed to IncomeShield? ☐ Yes ☐ No

If "Yes", please provide Hospital Registration No. (HRN) of the e-filed claim:

Note:

- If there is a CDL treatment (paired with a drug) combined and used at the same time with another CDL/non-CDL treatment, and this combination of drugs is not claimable under MSHL and Integrated Plans, please select the indication code CI00000 "Others" and do not select the indication code paired with the drug on the CDL.
- CDL treatments with "For Cancer Treatment" can continue to be submitted under indication code CI99999 "For Cancer Treatment".
- This note is subject to further updates from MOH.

Please complete this section if the cancer drug is not on the CDL (MOH).

2. Classification of Non-CDL

(a) What is the Non-CDL Classification of the cancer drug treatment being administered? Tick accordingly

☐ Class A	☐ Class B	☐ Class C	☐ Class D	☐ Class E	☐ Class F

Please advise the indication to provide why this cancer drug treatment falls under this classification.

(b) Has this cancer drug been approved for the patient's indication by any of the following bodies? Please tick at least one.

☐ HSA
☐ US FDA
☐ EMA
☐ TGA Australia
☐ Health Canada
☐ UK MHRA
☐ Others (Pls specify): _____
☐ None known

Annex A - Attending Medical Practitioner's Statement
Part 2 (To be completed by Doctor) (continued)

(c) If it is approved by a regulatory body, please specify the indication.	☐ Yes ☐ No
(d) Please provide weblink for any medical literature or international guidelines or attach relevant documents to support the Non-CDL Classification.	☐ Yes ☐ No
(e) If 2b) is "None Known", please advise if there is any Clinical Guidelines under NCCN and ESMO for the cancer drug use. If "Yes", please provide weblink for the relevant NCCN/ESMO guideline and provide the page number corresponding to the insured's treatment OR provide a hardcopy with highlights.	☐ Yes ☐ No
(f) Was the treatment brought in via Special Access Route (SAR) under Health Science Authority of Singapore (HSA)?	☐ Yes ☐ No

3. Other information of the Cancer Drug

(a) Dosage/Quantity prescribed	
(b) Date of treatment/Start date (mm/yyyy)	
(c) What is the number of treatment(s) required in the same month?	

4. Please provide us with a copy of the histopathology report pertaining to the cancer condition.

5. 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