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

Checklist for Medical/Accident/Living/Total and Permanent Disability Claim (Individual Policies)

Please submit your claim via email as follows:

Claims on Individual life policy: **csquery@income.com.sg**

Claims on Managed Healthcare System (Inpatient), IncomeShield policy: **healthcare@income.com.sg**

Claims on Affinity schemes policy (LUV/SAFRA/CEGIS/HomeTeamNS/OCBC Protect): **groupclaim@income.com.sg**

Dear claimant

We are sorry to learn of your illness/injury/hospitalisation. In order for us to process your claim, we require the following information and document(s) (Please tick '✓' the appropriate box and enclose 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.
(c) All overseas documents must be certified as true copies by a Notary Public.
(d) All documents submitted must be in English. Any documents which are in foreign languages must be officially translated to English by a certified translator/ interpreter.
(e) Income Insurance reserves the rights to request for additional documents when deemed necessary.
(f) Please keep the original final tax invoices (itemised bills), bills, receipts or relevant documents for the next 6 months. Income Insurance reserves the rights to call for the original copies of these documents for verification.
(g) Please continue to pay the premiums to keep your policy in force.

☐ **Total and Permanent Disability, Terminal Illness, Disability Care Benefit**

- ☐ Medical/Accident/Living/Total and Permanent Disability Claim Form (to be completed by claimant)
- ☐ NRIC or relevant identification documents (e.g. FIN card, passport) of claimant
- ☐ Attending Medical Practitioner's Statement (AMPS) (to be completed by attending doctor & submitted to us)
- ☐ Medical reports/Laboratory reports/Hospital Discharge Summary
- ☐ Your bank book/statement for crediting of claim proceeds. It must show the bank name, bank account number and full names of all bank account
- ☐ Medically boarded out letter (where applicable)
- ☐ Newspaper clipping and Police/Accident Report (if Total & Permanent Disability or Permanent Incapacity was due to accidental or violent causes)
- ☐ Termination letter from last employer OR CPF Statement showing last employment contribution (for DPS policy only)
- ☐ CPF Contribution Statement for the past 15 months (for DPS policy only)
- ☐ Dependant Booster Benefit Claim Form (for Family Protect policy only), to be completed by claimant
- ☐ Passport/Travel documents showing departure dates from Singapore and entrance dates to other country outside of Singapore for the last 24 months (to be provided if illness/injury is diagnosed or treated overseas)
- ☐ Proof of relationship if insured is different from policyholder (e.g. Birth certificate, Marriage certificate)
- ☐ Marriage certificate and screenshot from SingPass (My Profile > Family) showing current marital information of spouse if claim on family waiver benefit or Affinity schemes policy
- ☐ Birth certificate showing information of child and parent if claim on family waiver benefit

☐ **Dread Disease (Living), Female Illness, Senior Illness, Juvenile Illness, Special Illness, Mental Illness, Major Impact, Critical Impact, Cancer Hospice Care, Vital Function, Cancer Therapy, Therapy Support Benefit**

- ☐ Medical/Accident/Living/Total and Permanent Disability Claim Form (to be completed by claimant)
- ☐ NRIC or relevant identification documents (e.g. FIN card, passport) of claimant
- ☐ Attending Medical Practitioner's Statement (AMPS)^ (to be completed by attending doctor & submitted to us)
- ☐ Medical reports/Laboratory reports/Hospital Discharge Summary
- ☐ Your bank book/statement for crediting of claim proceeds. It must show the bank name, bank account number and full names of all bank account holders.
- ☐ Passport/Travel documents showing departure dates from Singapore and entrance dates to other country outside of Singapore for the last 24 months (to be provided if illness/injury is diagnosed or treated overseas)
- ☐ Proof of relationship if insured is different from policyholder (e.g. Birth certificate, Marriage certificate)
- ☐ Marriage certificate and screenshot from SingPass (My Profile > Family) showing current marital information of spouse if claim on Affinity schemes policy

^ Note: Please use the specific AMPS form (Refer to income.com.sg)

Medical Claim

☐ **IncomeShield, Family Plus, Annuity Hospital & Surgical, Managed Healthcare System (Inpatient)**

_____ Medical/Accident/Living/Total and Permanent Disability Claim Form (to be completed by claimant)

_____ Final hospital/medical bills & receipts

_____ Hospital discharge summary

_____ Medical reports, if available

_____ Settlement letter from the Insurer/Employer (If there is previous reimbursement from another Insurer/Employer)

_____ Insured's passport and eligible valid pass if insured is a foreigner and is claiming for Emergency overseas treatment

_____ CPF MediSave Statement showing Hospital Registration Number (HRN), for those bill(s) fully/partially paid using MediSave

_____ Your bank book/statement for crediting of claim proceeds. It must show the bank name, bank account number and full names of all bank account holders.

☐ **Hospital Benefit (Rider), Hospital Cash Benefit**

_____ Medical/Accident/Living/Total and Permanent Disability Claim Form (to be completed by claimant)

_____ Final hospital bills

_____ Hospital discharge summary

_____ Medical reports, if available

_____ Medical Certificates, if available

_____ Your bank book/statement for crediting of claim proceeds. It must show the bank name, bank account number and full names of all bank account holders.

☐ **Accident Claim (Accident Benefit)**

_____ Medical/Accident/Living/Total and Permanent Disability Claim Form (to be completed by claimant)

_____ Hospital discharge summary

_____ Medical Certificates

_____ Final hospital bills & receipts

_____ Medical reports

_____ Accident reports

_____ Police Report, if any

_____ Your bank book/statement for crediting of claim proceeds. It must show the bank name, bank account number and full names of all bank account holders.

_____ Passport/Travel documents showing departure dates from Singapore and entrance dates to other country outside of Singapore for the last 24 months (to be provided if illness/injury is diagnosed or treated overseas)

☐ **Maternity 360, Lady Plus/360**

_____ Medical/Accident/Living/Total and Permanent Disability Claim Form (to be completed by claimant)

_____ NRIC or relevant identification documents (e.g. FIN card, passport) of claimant

_____ Medical reports/Laboratory reports/Hospital Discharge Summary

_____ Child's birth certificate (for claim on child's benefit, if applicable)

_____ Child's health booklet (for claim on child's benefit, if applicable)

_____ Final itemised/detailed hospital bills

_____ Your bank book/statement for crediting of claim proceeds. It must show the bank name, bank account number and full names of all bank account holders.

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Medical/Accident/Living/Total and Permanent Disability Claim (Individual Policies)

Important Notice

(a) The acceptance of this form is **NOT** an admission of liability on the part of Income Insurance. Any documentary proof or report required by Income Insurance shall be furnished at the expense of the policyholder or claimant. To avoid delay in processing your claim, please submit the duly completed claim form together with the supporting documents within 30 days from date of occurrence.

(b) All benefits under IncomeShield will end when the insured, who is a foreigner, no longer has an eligible valid pass, and we will not be legally responsible for any further payment under this policy. Eligible valid pass means a valid pass with a foreign identification number (FIN) recognised by the Immigration and Checkpoints Authority of Singapore (ICA), for example, student's pass, work pass, long term pass and dependant's pass.

(c) If you make a claim for family waiver benefit under products such as Star Secure and Star Secure Pro, all particulars, information, declaration and authorisation provided in this form relating to the insured shall be taken to refer to the family member in connection with the claim for the family waiver benefit.

(d) **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.**

Please tick '✓' the appropriate box:

Claim Type (Individual life policy):		
☐ Accident Benefit	☐ Major Impact/Critical Impact Benefit	☐ Mental Illness
☐ Dread Disease Benefit	☐ Cancer Hospice Care Benefit	☐ Maternity 360
☐ Hospitalisation Benefit	☐ Disability Care Benefit	☐ Lady Plus/360, Female Illness
☐ Total and Permanent Disability Benefit	☐ Senior Illness	☐ Vital Function Benefit
☐ Terminal Illness Benefit	☐ Juvenile Illness	☐ Cancer Therapy/Therapy Support Benefit
☐ Family Waiver Benefit	☐ Special Illness	☐ Others _____
Claim Type (IncomeShield):	**Claim Type (Affinity schemes policy):**	**Claim Type (Managed Healthcare System):**
☐ Outpatient treatment	☐ LUV	☐ Inpatient care
☐ Inpatient/ Day surgery	☐ SAFRA	
☐ Emergency overseas treatment	☐ CEGIS	
☐ Daily cash rider	☐ HomeTeamNS	
☐ Others _____	☐ OCBC Protect	

Policy number(s)	Plan type	Claim number

Particulars of insured

Full name of insured (as shown in NRIC/FIN card/Passport/Birth Certificate)	NRIC/FIN/Passport/Birth Certificate number of insured	Gender ☐ Male ☐ Female
Relationship to policyholder	Martial status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Occupation (If unemployed, please indicate last occupation)	☐ Employed ☐ Unemployed ☐ Self Employed	Date of birth (dd/mm/yyyy)
Name and address of employer or last employer (if unemployed)	Period of employment (dd/mm/yyyy) From _____ To _____	
Duties performed at work		
Contact number of insured (Hand phone) (Home) (Office)	Email address of insured	

Particulars of policyholder/assignee (if different from insured)

Full name (as shown in NRIC/FIN card/Passport) of policyholder/assignee (if policy is assigned)	NRIC/FIN/Passport number of policyholder/ assignee (if policy is assigned)	Gender ☐ Male ☐ Female
Contact number of policyholder/assignee (Hand phone) (Home) (Office)		

For Accident/Disability claims only

1. a. Date the insured last worked (dd/mm/yyyy) : _____

   b. Date the insured returned to work (dd/mm/yyyy) : _____ OR

   Date the insured expect to return to work (dd/mm/yyyy) : _____

Medical Condition/History

2. Details of illness/injury

Is the condition/disability suffered due to ☐ Illness ☐ Accident

a. If the condition/disability suffered is due to illness, please provide

(i) Diagnosis _____

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

(iii) Describe in detail all symptoms and nature of medical condition/disability suffered.

(iv) Have any of the insured's family members suffered from a similar or related illness? ☐ Yes ☐ No

If "Yes", please provide the following details.

Relationship of family member	Nature of illness	Date of diagnosis	Age diagnosed	Treatment details

b. If the disability suffered is due to accident, please provide

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

(iii) Place of accident _____

(iv) Detailed description of nature of injuries/disability suffered

(v) Detailed description of accident (Please enclose a copy of the police report, if any)

(vi) If you are claiming for accidental injuries resulting in inpatient dental treatment, please advise which tooth/teeth were injured?

Was/were the injured teeth sound and natural? ☐ Yes ☐ No

c. Is the insured currently confined to any of the following? Please tick accordingly. ☐ Yes ☐ No

☐ Bed ☐ House ☐ Hospital ☐ Others _____(Please specify)

If confined, please state the period of confinement.

Start Date (dd/mm/yyyy) _____ End Date (dd/mm/yyyy) _____

If not confined, please briefly describe insured's daily activities _____

Medical Condition/History (continued)

d. (i) Please state the periods of hospitalisation

Name of hospital	Period of hospitalisation	
	From (dd/mm/yyyy)	To (dd/mm/yyyy)

(ii) Has the insured been given hospital/medical leave? ☐ Yes ☐ No

If "Yes", please state the start and end date of the hospital/medical leave.

Start Date (dd/mm/yyyy) _____ End Date (dd/mm/yyyy) _____

3. How was the insured admitted to the hospital?

☐ Referral by a General Practitioner/Specialist/Other hospital (please delete accordingly)

Please provide the name and address of referring doctor/hospital.

_____

_____

☐ A & E department

4. Please provide the name, contact number and address of the doctor who is treating the insured for his current condition/injury.

5. Was surgery performed for this condition/injury? If "Yes", please provide details below. ☐ Yes ☐ No

Surgical operation/procedure	Date(s) of operation/procedure (dd/mm/yyyy)	Surgical code/table (please refer to your doctor)

6. Is the condition/disability diagnosed or treated outside of Singapore? If "Yes", please provide details below. ☐ Yes ☐ No

a. Reason why the insured's condition/disability is treated outside of Singapore

b. Date the insured left Singapore (dd/mm/yyyy)

c. The purpose of the overseas visit

d. What was the intended length of the overseas visit	From (dd/mm/yyyy)	To (dd/mm/yyyy)

7. Has this or similar condition/injury been treated before? If "Yes", please provide details below. ☐ Yes ☐ No

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

Medical Condition/History (continued)

8. Has the insured seen other doctors besides those indicated above? If "Yes", please provide details below. ☐ Yes ☐ No

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

9. Please provide details of the insured's regular doctor(s) and company doctor(s) below:

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

Other insurances

10. 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

11. 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/ Sum assured (S$)	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.

Note: It is important to inform us if you are claiming from other insurance companies, your employer or any other parties for the same bill. You can only claim or be reimbursed for the amount that you have incurred regardless of the number of medical insurance policies you may have. We reserve the right to recover the excess amount paid to you.

Other information (Compulsory to complete)

12. 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: _____

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. *All future medical claims or claims payment by instalments will be paid to the bank account provided by you in our record. For other claims, we may request for a copy of your bank book or statement for account verification before we make payment.*
2. *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.*
3. *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.*

Preferred servicing advisor for this claim (for individual life policy only)

Do note that all communications pertaining to this claim will be sent to the advisor who last sold to the policyholder an individual life policy. If the claimant prefers to have a different servicing advisor for this claim, please indicate below and provide the details of the preferred servicing advisor*.

☐ I prefer to have the communications relating to this claim copied to the preferred servicing advisor* indicated below.

Name of advisor: _____

Contact number of advisor: _____

* The preferred servicing advisor must be an advisor to the policyholder's (where this claim is relating to) existing individual life policy with Income Insurance. Otherwise, your preference indicated above will not be valid and communications pertaining to this claim will be sent to the advisor who last sold to the policyholder an individual life policy.

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 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.
6 I agree that a copy of the authorisation in this form is valid and binding as an original copy.
7. I consent and agree to the transfer and disclosure, at any time and without notice or liability to me, of any policy or claim information, including about the life insured and claimant(s), in the insurer's possession to the Central Provident Fund Board and its approved insurer(s), and their representatives and third party service provider(s) for:
   a. the purpose of administering the claims made under the Dependant's Protection Insurance Scheme or any other insurance scheme referred to in the Central Provident Fund Act 1953. which I may be insured under; or
   b. any purpose connected with the administration or operation of the accounts maintained by the Board for me under the Central Provident Fund Act 1953. In addition, I hereby agree that this consent shall remain valid notwithstanding my death.
8. I also understand that the claim benefit that I will be receiving under Dependants' Protection Insurance Scheme, subject to the approval of my claim application, will be the sum assured that I was covered for as at the date when my incapacity commenced as stated in my medical certification.
9. 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.
10. 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.
11. 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).
12. 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.

Declaration and authorisation (continued)

13. 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.
14. 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.*
15. I understand and agree that a copy of communication by email or postal mail between Income Insurance and I relating to this claim will be sent to the advisor who last sold to the policyholder an individual life policy except where I have indicated in this form a preferred servicing advisor who is also an advisor to the policyholder's existing individual life policy with Income Insurance.
16. 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.
17. 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.
18. 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.
19. 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.

If you make a claim for family waiver benefit under products such as Star Secure and Star Secure Pro, all particulars, information, declaration and authorisation provided in this form relating to the insured shall be taken to refer to the family member in connection with the claim for the family waiver benefit.

Full name (as shown in NRIC/FIN card/Passport) and signature/thumbprint of **policyholder/ assignee** (if policy is assigned)	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/assignee)	NRIC/FIN/Passport number	Date signed (dd/mm/yyyy)
Full name (as shown in NRIC/FIN card/Passport) and signature/thumbprint of **family member** who is 21 years old or above (if claim on family waiver benefit)	NRIC/FIN/Passport number	Date signed (dd/mm/yyyy)
Full name (as shown in NRIC/FIN card/Passport) and signature of **claimant** who is 21 years old or above (if the policyholder/assignee/insured/family member does not have the mental capacity or is below 21 years old)	NRIC/FIN/Passport number	Date signed (dd/mm/yyyy)
Claimant's relationship to policyholder		
Contact number of claimant (Hand phone) (Home) (Office)	Email address of claimant	
Please indicate why policyholder/assignee/insured/family member is unable to sign		

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.