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

ElderShield Supplement/PrimeShield/Care Secure Claim

Dear Policyholder

We are sorry to learn of your disability.

In order for us to process your claim, please:

1. Complete the attached Claim Form as best as you can. If you are unable to do so, please have it completed by your immediate family member or caregiver.

2. Call the clinic to make an appointment for the disability assessment. Please refer to the list of appointed assessors at income.com.sg. The fee for the assessment is to be paid by you. Please note that this is required in order for the assessor to proceed with the assessment.

3. Bring along the following for the appointment:
   a. Completed ElderShield Supplement/PrimeShield/Care Secure Claim Form
   b. A copy of your NRIC/FIN card/Passport, the payee's NRIC/FIN card/Passport and your caregiver's NRIC/FIN card/Passport (if payee and/or caregiver is other than the Policyholder)
   c. Completed Letter of Undertaking and Indemnity (if payee is other than the Policyholder)
   d. Hospital medical records and Inpatient discharge summary. Please note that this is required in order for the assessor to proceed with the assessment.
   e. Medicine (if any)

4. Request the appointed assessor for a printout of the disability assessment report and submit it together with items 3a, 3b, 3c and 3d to us. If the report is not made available to you, please indicate the date and place where the disability assessment was done with your claim submission.

5. If you have already had a disability assessment done for your Basic ElderShield or CareShield Life claim with Agency for Integrated Care (AIC), within the last 3 months, you need not undergo the assessment again. You will only need to submit items 3a, 3b, 3c and 3d to us and indicate the date and place where the disability assessment was done.

6. Submit your claim via email to us at healthcare@income.com.sg.

Once we have received all the required documents/information, we will process your claim and inform you of the outcome as soon as possible.

Should you have further queries, we would be most happy to assist you via your preferred mode of contact at income.com.sg/contact-us.

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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 disability assessment.

b) Please note that the contact details provided in this form will not be updated in our records. We will correspond with you based on your registered contact details with us. To ensure your contact details with us are updated, please scan the QR code on page 1 of this form to update your particulars with us.

To be completed by Policyholder

Policy number(s)	Plan type	Claim number

Personal particulars

Policyholder

Full name of Policyholder (as shown in NRIC/FIN card/Passport)	Gender ☐ Male ☐ Female
NRIC/FIN/Passport number of Policyholder	Date of birth (dd/mm/yyyy)
Address of Policyholder	
Contact number of Policyholder (Hand phone) (Home) (Office)	Email address of Policyholder

Full-time/part-time caregiver (Age above 21 years old)

Full name of caregiver (as shown in NRIC/FIN card/Passport)	NRIC/FIN/Passport number of caregiver
Address of caregiver	
Relationship to Policyholder	
Contact number of caregiver (Hand phone) (Home) (Office)	Email address of caregiver

Bank account for benefits payment once claim is admitted (Please submit a copy of your bank book or 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.)

Note: For payment to third party (family member or caregiver), please complete the attached Letter of Undertaking & Indemnity.

Name of bank account holder(s)	Bank account number
Name of bank	

Details of dependant (for Care Secure only) or child below age 21 (for PrimeShield only)

Full name (as shown in NRIC/FIN card/Passport/Birth Certificate) of dependant/youngest child	Date of birth (child)	Place of birth (child)	Gender ☐ Male ☐ Female
NRIC/FIN/Passport/Birth Certificate number *(Please submit copy of NRIC/FIN card/Passport/Birth Certificate)*		If the child is legally adopted, please state Date of Adoption (dd/mm/yyyy): _____ (*Please submit copy of legal adoption papers*)	

Details of claim and medical history

1. Please indicate the date of disability assessment and panel assessor's name and clinic:

Date of disability assessment	Panel assessor's name	Panel assessor's clinic

2. Please state the conditions that the insured is suffering from and resulting in this claim in the table below.

Condition	Date of Diagnosis	Date symptoms first started	Description of symptoms

3. Doctors consulted for the conditions:

Condition	Date/Period of consultation(s)	Name and address of doctors consulted

4. If disability is due to accident, please provide date of accident _____ (dd/mm/yyyy), and attach a copy of accident report.
If no report is available, please describe: (a) nature of the accident; and (b) extent of injuries sustained.

5. Does the insured suffer from any other medical condition or disability? ☐ Yes ☐ No
If yes, please provide details:

Condition	Date condition was first diagnosed	Name and address of doctors consulted

6. Name and address of the insured's regular doctor:

Other insurance

Does the insured have insurance coverage with other insurance companies? ☐ Yes ☐ No
If yes, please provide details:

Name of insurance company	Policy number	Date of issue (dd/mm/yyyy)	Type of plan	Sum assured (S$)	Claim notified (Yes/No)	Claim paid (Yes/No)

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

If the Policyholder has previously been assessed by a doctor to lack mental capacity*, the Policyholder's appointed donee(s)/deputy(s), or caregiver if a donee(s)/deputy(s) has not been appointed, is to complete this section and sign/affix thumbprint. The mentally incapacitated Policyholder need not sign off/affix thumbprint.

* A separate doctor's memo should be submitted to indicate that the Policyholder lacks mental capacity, including the relevant medical reason(s).

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 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.
7. 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.
8. 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.
9. 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).
10. 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.
11. 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.
12. 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.*

Declaration and authorisation (continued)

+ *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.*

13. 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 policy servicing advisor of the ElderShield Supplement, PrimeShield or Care Secure insurance.
14. 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.
15. 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.
16. 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 of Policyholder (as shown in NRIC/FIN card/Passport)	NRIC/FIN/Passport number	Signature or thumbprint of Policyholder	Date signed (dd/mm/yyyy)

To be completed if form is filled up by family member

Full name of family member (as shown in NRIC/FIN card/Passport)	NRIC/FIN/Passport number of family member	Relationship to Policyholder
Address of family member	Signature of family member	Date signed (dd/mm/yyyy)

Contact number of family member (Hand phone) (Home) (Office)	Email address of family member

Important Note:

1. **This Letter of Undertaking and Indemnity is a legal document. Please seek legal advice if you have any enquiries. Your completion of this letter will facilitate the prompt processing of your claim.**
2. **Please complete this form if payment is to be made to a Third Party.**

To be completed by payee

To: Income Insurance

Part I: Letter of Undertaking & Indemnity

I/We declare that I am/we are the main caregiver(s) of the Policyholder, _____

Full name of Policyholder (as shown in NRIC/FIN card/Passport)

_____ of NRIC number _____

NRIC/FIN/Passport number of Policyholder

Policy number _____

In consideration of Income Insurance agreeing, at the Policyholder's/my/our request to pay the benefits which the Policyholder is entitled to under Income Insurance's ElderShield Supplements, PrimeShield or Care Secure insurance ("the Benefits") to me/us, I/we agree and undertake as follows :

1. That I/we will first use and apply the Benefits paid by Income Insurance for the care and benefit of the Policyholder.
2. That I/we will inform Income Insurance immediately upon becoming aware that the Policyholder has passed away or ceases to be entitled to the Benefits. I/we will repay any Benefits which the Policyholder is not entitled or ceases to be entitled to upon written demand by Income Insurance.

I/We agree and undertake that if I/we fail to make such repayment, I/we will fully indemnify Income Insurance against any loss, damage, cost and expense whatsoever, including any legal cost on a full indemnity basis, which may be incurred by Income Insurance as a result of my/our failing to fully repay the Benefits or if Income Insurance has to enforce its rights under this Undertaking and Indemnity.

Part II: Direct credit authorisation

Kindly attach a copy of the bank book or statement showing the bank's name, bank account number and full names of all bank account holders for our action.

I authorise Income Insurance to credit the Benefits into this account and to verify my/our account with the bank:

Full name of account holder(s) : _____

Name of bank : _____

NRIC/FIN/Passport number : _____

Account number : _____

Details of payee (Age above 21 years old)		
Full Name of payee (as shown in NRIC/FIN card/Passport)	NRIC/FIN/Passport number of payee	Contact number of payee
Address of payee		Email address of payee
Signature of payee	Relationship to Policyholder	Date signed (dd/mm/yyyy)
Full Name of Policyholder (as shown in NRIC/FIN card/Passport)	Signature/thumbprint of Policyholder	Date signed (dd/mm/yyyy)

For homes or institutions only (If benefits are to be made to the home or institution)			
Full name of home or institution		Address of home or institution	
Full name of authorised officer	Contact number of authorised officer	Official stamp of home or institution	
Signature of authorised officer	Date signed (dd/mm/yyyy)		
Full Name of Policyholder (as shown in NRIC/FIN card/Passport)		Signature/thumbprint of Policyholder	Date signed (dd/mm/yyyy)