

CHECKLIST FOR TOTAL AND PERMANENT DISABILITY CLAIM

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 following 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. For each item provided, please tick '√' if applicable.
- (c) Please continue to pay the premiums to keep your policy in force.
- (d) Please submit all claim documents through your respective union upon verification.

- _____ Medical/Accident/Living/Total & Permanent Disability Claim Form (to be completed by Claimant)
- _____ Attending Physician's Statement (APS) (to be completed by attending physician & submitted to us)
- _____ Medical reports/Laboratory reports/Hospital Discharge Summary
- _____ Medically boarded out letter (where applicable)
- _____ Newspaper Cutting and Police/Accident Report (if Total & Permanent Disability was due to accidental or violent causes)

GH/NTPD/10/2009

TOTAL AND PERMANENT DISABILITY CLAIM FORM

Important Notice

The acceptance of this form is NOT an admission of liability on the part of NTUC Income. Any documentary proof or report required by NTUC Income 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.

Particulars of Union/Association Member

Name of Union/Association ¹		Name of Member (as shown in NRIC/PP)		NRIC/Passport No.
Address of Member				
Contact No. (O) _____ (H) _____ (Hp) _____			Date (dd/mm/yyyy) & Place of birth	
Union/Association membership No.		Membership type Ordinary/General ¹ Branch Member	Date joined Union/Association	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

To be completed if member is a Union/Association leader

Position in Union/Association	Date elected as Union/Association leader (dd/mm/yyyy)
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To be completed if claim is for spouse (Please attach marriage certificate as proof of relationship)

Name of Spouse	NRIC/Passport No.	Date (dd/mm/yyyy) & Place of birth
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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)		

NTUC INCOME reserves the right to request for documentary evidence related to **Details of Occupation**.

Details of Disability

Disability suffered due to <input type="checkbox"/> illness (date symptoms started) _____ (dd/mm/yyyy) <input type="checkbox"/> accident (date/time of accident) _____ (dd/mm/yyyy)		
Describe in detail the disability suffered		
Date you last worked (dd/mm/yyyy)	You are currently confined to <input type="checkbox"/> bed <input type="checkbox"/> house <input type="checkbox"/> hospital <input type="checkbox"/> N.A	Date you returned/expect to return to work (dd/mm/yyyy)

¹ Delete where applicable.

GH/NTPD/10/2009

Details of Doctor(s) consulted or Hospital(s) admission for this disability		
Name(s)	Address(es)	Admission Date(s) (dd/mm/yyyy)
Details of your regular doctor or any other doctor(s) consulted for any other medical conditions		
Name(s)	Address(es)	Reason for consultation

Other Claims

Is the Member/Spouse 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.						<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Employer, Insurance Company etc.	Policy No.	Date of Issue	Type of Plan	Claim Amount	Claim Notified (Yes/No)	Claim Paid (Yes/No)

Declaration

1. I hereby declare that the foregoing statements are true, correct and complete, and I have not withheld any material fact from NTUC Income.

2. I agree and authorise:

a) Any medical institution or medical practitioner, or insurer, or organisation or person to release to NTUC Income any information as requested by NTUC Income; and

b) NTUC Income to release any relevant information concerning me/my spouse to any medical institution or medical practitioner, or insurer or organisation or person.

A photocopy of this form is valid as an original copy.

Signature of Member

Date (dd/mm/yyyy)

Signature of Spouse
(To be completed only if claim is for spouse)

Date (dd/mm/yyyy)

To be completed by Union/Association

We hereby verify that the statements given are true and complete, that the above member/member's spouse³ is eligible for the NTUC GIFT scheme and the member was in our membership roll at the date of member's/member's spouse's³ disability.

Name

Signature

Designation: President/General Secretary/Executive Secretary/
Treasurer/Director/NTUC Membership Dept [for GB members]³

Date (dd/mm/yyyy)

Union/Association stamp

³ Delete where applicable.