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

Please email the completed claim form and required documents:

To: groupclaim@income.com.sg
CC: claims@mycg.com.sg

Group Personal Accident Insurance Claim Form
(For Students)

Important notes

The acceptance of this form is NOT an admission of liability on the part of Income. Any documentary proof or report required by Income must be given at the expense of the policyholder or claimant. Please submit the completed claim form together with supporting documents within 30 days from the date of accident.

Please ensure that all sections of the claim form are completed, incomplete form will be returned to you for completion.

Supporting documents for the type of claim (please tick accordingly)

Medical Expenses:

- ☐ Final tax invoice(s)/receipt(s)
- ☐ Referral letter, test reports, A&E visit summary, doctor's memo stating diagnosis & cause etc, if applicable
- ☐ Police report, if applicable
- ☐ For hospitalisation/day surgery, a copy of Inpatient discharge summary/Day surgery form/attending physician's medical report
- ☐ Shield Plan's settlement letter if there is any payment by Medisave-approved Integrated Shield Plan

Permanent and Total/Partial Disability:

- ☐ Medical reports/Laboratory reports/Hospital Discharge Summary
- ☐ NRIC or relevant identification documents (e.g. passports, birth certificates) of claimant
- ☐ Accident report from school/centre
- ☐ Newspaper Clipping and Police Report

POLICYHOLDER: INSTITUTE OF TECHNICAL EDUCATION (ITE)

[ ] JANUARY INTAKE
Policy No. 2100530141

[ ] APRIL INTAKE
Policy No. 2100627336

Particulars of Insured

Full Name (as shown in NRIC, FIN or BC)	NRIC, FIN or BC number	Gender ☐ Male ☐ Female
Date of birth (dd/mm/yyyy)	Nationality	Class NOT APPLICABLE
Residential address	Contact details (Mobile) (Home) (Email)	

If your contact particulars (i.e. address, contact number and email) indicated in this form are different from your existing records with us, we will not update all your existing policies with the new contact particulars.

Details of accident

Date and time of accident	Place of accident
Did the accident occur during supervised CCA? ☐ Yes ☐ No If 'Yes', please state the type of CCA: _____	Did the accident occur during organised school activities? ☐ Yes ☐ No
Describe how the accident happened.	
Describe the injuries sustained and the part(s) of the body injured.	

Other information

Have you claimed or do you intend to claim from any insurer, other employer or any other parties for reimbursement of your medical bills? If 'yes', please state the party that you are claiming from and submit a copy of the settlement letter or payment voucher from the other party. Note: It is important that you inform us if you are claiming from another insurer, other employer or any other parties for the same bill. You can only claim or be reimbursed once for the amount that you have incurred, regardless of the number of medical insurance policies you may have. We reserve the right to recover if there is any excess amount paid to you.	☐ Yes ☐ No

Payee's details (STUDENT)

Name of payee (as shown in the bank account)	NRIC, FIN, Passport or UEN number (as shown in the bank account)	Relationship to the insured	Nationality	Country of residence

Note: If payment is to be made to the parent, a copy of the student's birth certificate is required as proof of relationship.

Payment options:

☐ **PAYNOW (RECOMMENDED)**

- PayNow account must be registered with NRIC, FIN or UEN.
- PayNow account registered with mobile number or Trust Bank **will not** be applicable.

☐ **DIRECT CREDIT**

- It must be a Singapore bank account denominated in Singapore Dollar.
- It is compulsory to submit a copy of bank book/statement for verification purpose.

Name of bank _____

Account number _____

Personal data collection statement (A photocopy of this authorization is valid as an original copy)

By providing the information and submitting this application or transaction, I/we consent and agree to Income Insurance Limited ("Income"), its representatives, agents, relevant third parties, Income's appointed insurance intermediaries and their respective third party service providers and representatives (collectively "Income Parties") (referred to in Income's Privacy Policy at http://www.income.com.sg/privacy-policy) to collect, use, and disclose any personal data in this form or obtained from other sources, including existing personal data provided and any future updates, (collectively "personal data") for the purposes of processing and administering my/our insurance application or transaction, providing me/us with financial advice and/or recommendation on products and services, managing my/our relationship and policies with Income including sending me/us corporate communications and notices on updates and servicing, research and data analytics, and in the manner and for the purposes described in Income's Privacy Policy.

Where the personal data of another person(s) (for example, personal data of my family, employee, payee/payer or beneficiary) is provided by me/us or from other sources to Income Parties, I/we represent and warrant that:

- I/we have obtained their consent for the collection, disclosure and use of their personal data; and
- I am/we are authorised to give any authorisation, approval and consent on their behalf to collect, use or disclose, their personal data,

for the purposes as set out in this Personal Data Use Statement.

For the purpose of this application and any claim in connection with my/our policy(ies) with Income, I/we also authorise, agree and consent to (whether this application or transaction is accepted or refused) the following:

a) The medical source, insurance office, reinsurer, or organisation to release to Income any medical or relevant information to do with me or the insured;
b) Income to collect from 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 or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests for Income to underwrite and evaluate me or the insured health status or condition in relation to this application and any claim in connection with my/our policy(ies) with Income.

When submitting a claim for an insurance policy, I/we consent and agree that the personal data will also include any subsequent information collected on health or any information that is necessary for Income to decide whether to pay the claim, such as test results, medical examination results, and health records from medical sources such as medical examiners or laboratories.

I/We authorise, consent and agree to the following:

- Income Parties to collect from and/or disclose to the group policyholder, the personal data for all the relevant purposes listed above and in Income's Privacy Policy including to respond to enquiries from the group policyholder for the purposes of this application and policy servicing matters, including confirmation of eligibility for the cover; and
- The group policyholder to disclose the personal data to Income Parties for all the relevant purposes listed above and in Income's Privacy Policy.

Please refer to Income's Privacy Policy for more information, including access and correction of my personal data and consent withdrawal.

Declaration and authorisation by Insured/parent/legal guardian

I certify that the information in this form is true and complete and I have not withheld any material information.

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.

For the purposes of policy administration including processing and investigating this claim, and deciding whether Income is to insure or continue to insure me for my insurance applications or policies,

a. I authorise any person or organisation who has relevant information pertaining to this claim, including any medical practitioner, health care provider or institution, insurance company, and investigative agencies, to release and exchange such information (including personal health information) requested by Income and/or its claims service providers.

b. I authorise Income and its claims service providers to collect, use, disclose and to exchange with the persons or organisations listed above any information (including personal health information).

c. I am authorised to disclose information (including personal health information) about the insured person if this claim is made on behalf of them.

I confirm that all documents submitted to Income including bills and invoices are copy of the original documents and I am aware that I am required to retain all original documents for a period of 6 months from claim submission date for verification by Income when required. I am aware that Income may reject my claim should it discover that the document(s) that I have submitted is not a copy of the original document(s).

I confirm that I have paid in full all the bill(s)/invoice(s) that I have submitted to Income for reimbursement and I have not made any claim and will not make any claim from any other source for the same bill(s)/invoice(s). If I have made a claim from other source, I agree that I will provide a copy of the settlement agreement between me and such other source. I am aware that Income will not reimburse me if I have received a full reimbursement from any other source. If I do not receive full reimbursement from other source, I am aware and understand that Income will only reimburse me the balance of the bill/invoice that has not been paid to me by other source. In the event Income has made a reimbursement to me and I have claimed from other sources and be reimbursed for more than what I incurred in total, I agree that Income has the right to recover any payment made by Income to me.

I agree that a photocopy or electronic version of this authorisation shall be as valid as the original.

Name of Insured	Signature of Insured (If Insured is age 21 years and above)	Date (dd/mm/yyyy)

If Insured is below 21 years old, the following is to be completed by the parent or legal guardian of the Insured.

Full Name (as shown in NRIC or FIN)	Signature	NRIC or FIN number

Relationship to the Insured	Date (dd/mm/yyyy)