

Other Insurance

a.) Are you covered for medical expenses by any other insurance company(ies), your employer or any other parties? If Yes, please state details below.	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.) Have you submitted a claim for the bill(s) concerned to any insurance company(ies), your employer or any other parties yet? If Yes, please state details below.	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.) Have you been bankrupt or insolvent or has executed any deed or transfer for the benefit of creditors and since becoming interested in the policy? If Yes, please give details.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Note: It is important to tell us if you are claiming from other insurance companies, your employer or any other parties for the same bill. You may be committing an offence if you claim for or are reimbursed more than the amount that you have paid, regardless of the number of medical insurance policies you may have.

Payment

Please tick box to indicate mode of payment.

Pay me by cheque Credit to my bank account as follows:

Name of bank	Branch	Account No.
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For Group Policyholders Only

Name of member/employee (if different from patient)	NRIC No.
Name of company/union	Date joined company/union (DD/MM/YY)
Name of authorised officer	Contact No.

Payment to be made to:

Company/Union (please complete payment mode above) Employee/Member (including payment into Medisave account)

Others; please specify _____

Declaration

1. I hereby declare that the above statements are true and complete and I have not withheld any material fact from NTUC Income. I consent to NTUC Income obtaining medical information from any doctor I/my child have/has consulted and I authorised the giving of such information.
2. I hereby consent to the transfer and disclosure, at any time and without notice or liability to me of any medical information on me in the insurer's possession to the Central Provident Fund Board for:
 - (a) the purpose of making of a claim under the Dependants' Protection Insurance Scheme or any other insurance scheme referred to in the Central Provident Fund Act (Chapter 36) 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 (Chapter 36).

In addition, I hereby agree that this consent shall remain valid notwithstanding my death.
3. I also understand that the claim benefit that I will be receiving under Dependants' Protection Insurance, 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.
4. I agree that a photocopy of this form shall be as valid as the original.

Name of policyholder (Individual)	NRIC No.
Signature of policyholder	Date (DD/MM/YY)

Name of patient (if different from above)	NRIC No.
Signature of patient (if above 21)	Date (DD/MM/YY)

Name of authorised officer (for group policyholders only)	Company/union stamp
Signature of authorised officer	Date (DD/MM/YY)

For Office Use Only

Claim No.	Premium next due date	Hospital/accident benefit (per day/week)\$	
No. of hospital days	Amount (\$)	Signature of officer(s)	Remarks
No. of Medical leave	Amount (\$)		
Please pay	Total (\$)	Date	