ntuc income

GROUP HOSPITALISATION BENEFIT 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.

Please submit the following:
1. Certified true copy of Medical Certificate/Final Hospital Bills/Inpatient Discharge Summary.
2. Proof of relationship (certified true copy of Marriage Certificate or Birth Certificate) if claim is in respect of a dependant.

Group Policy No.	Name of Union
Plan Type	Claim No.

Particulars of Member

Name of Member (Claimant)	Gender ☐ Male ☐ Female	NRIC No.
Occupation / Division	Date of Birth (dd/mm/yyyy)	Age
Name of Dependant	Gender ☐ Male ☐ Female	NRIC No.
Relationship to Member	Date of Birth (dd/mm/yyyy)	Age
Address of Member		
Contact No. (O) (H) Hp)		Email

Details of Hospitalisation

1. Hospital admitted to ____

2. Admitted on (dd/mm/yyyy) ______________________ Discharged on (dd/mm/yyyy) ______________________

3. Nature of injury or illness

Declaration by Member

1. I hereby declare that the above statements are true 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 to any relevant information concerning me/my child 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 (Claimant)	Date (dd/mm/yyyy)

GH/CL/10/2009

NTUC Income Insurance Co-operative Limited
NTUC Income Centre 75 Bras Basah Road Singapore 189557 | t. 63 INCOME (6346 2663) | f. 6338 1500 | csquery@income.com.sg | www.income.com.sg

POSB / DBS ACCOUNT NO. ______________________________________

Certificate of Union Membership

Name of Member		Membership No.
Office of Employment		Date Joined Union (dd/mm/yyyy)
Payment to be made to ☐ Union ☐ Member		
I hereby certify that the above named is a member of ______________________________(name of Union)		
Name of Authorised Officer		Company/Union Stamp
Signature of Authorised Officer	Date (dd/mm/yyyy)	

For NTUC INCOME Use

Claim No.		Next Premium Due Date
Hospital benefit per day $	No. of days hospitalised	Total amount to pay ($)
Signature of Officer(s)		Date (dd/mm/yyyy)
Remarks		

GH/CL/10/2009