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Tel: 6788 1777 · Fax: 6338 1500
Enquiries: www.income.com.sg/enquiry

NTUC GIFT
Death Claim Form

Dear Claimant

We are sorry to learn of the death of our Life Insured. In order for us to assess your claim, please complete this form in FULL and attach the required documents.

Important notes

(a) All items must be duly completed to avoid delay to the claim process. Please indicate as "N.A." if not applicable.

(b) Upon receipt of ALL the required documents, we will assess your claim and inform you of the outcome as soon as possible. Please allow approximately 4 - 6 weeks for claim assessment, subject to submission of all required documents.

(c) The acceptance of this form is NOT an admission of liability on the part of Income. Any documentary proof or report required by Income shall be furnished at the expense of the Claimant. To avoid delay to the claim process, please submit the duly completed claim form together with the supporting documents **within 90 days from date of death**.

(d) **Please submit all claim documents through your respective union (for Ordinary Branch) or NTUC Membership Dept (for General Branch/U Club/UAssociate).**

(e) 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.

Information on member

Full Name of member (as shown in NRIC, FIN or passport)	NRIC, passport or FIN number	Nationality	Country of residence

Information on insured person (deceased)

Insured person (deceased) is: ☐ Member ☐ Member's Spouse	Full Name of insured person (as shown in NRIC, FIN or passport)		NRIC, passport or FIN number
Date of birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female	Nationality	Country of residence
Date (dd/mm/yyyy) and time of death	Place of death		Was any Coroner's Inquest held? ☐ Yes ☐ No
Cause of death			

Death due to:

☐ Illness

Diagnosis _____ Date symptoms started _____ (dd/mm/yyyy)

☐ Accident ☐ Suicide

Date of incident _____ (dd/mm/yyyy) Time of incident _____

Place of incident _____

Did the incident occur during working hours of the insured person? ☐ Yes ☐ No

Employment status on date of death ☐ Employed ☐ Unemployed	Date last worked (dd/mm/yyyy)
If employed, did the insured person report for work on date of death or accident? ☐ Yes ☐ No	

Information on claimant

Full Name (as shown in NRIC, FIN or passport)	NRIC, passport or FIN number	Gender ☐ Male ☐ Female	
Relationship to deceased (please attach proof of relationship such as Marriage Certificate or Birth Certificate)		Nationality	Country of residence
Contact number (Mobile) (Office) (Home)		Email	
Mailing address			

Other information

Has the deceased or claimant been bankrupt or insolvent or has executed any deed or transfer for the benefit of creditors since becoming interested in the policy?
If "Yes", please provide details.

Policyholder	☐ Yes	☐ No	Details: _____
Assignee	☐ Yes	☐ No	Details: _____
Donee/ Court Appointed Deputy	☐ Yes	☐ No	Details: _____
Insured	☐ Yes	☐ No	Details: _____

The following documents are attached to this application: [Please tick (√) if applicable]

☐ Death claim form (to be completed by next-of-kin and verified/endorsed by the respective union)

☐ Certified true copy of Death Certificate (for overseas death, the original Death Certificate must be certified by your lawyer or any Notary Public)

☐ Letter from Immigration and Checkpoint Authority (ICA) – this letter is issued by ICA for Singaporeans or Permanent Residents (PR) who died overseas. It confirms receipt of the Singapore IC, Passport and overseas Death Certificate.

☐ Repatriation Report (if body was repatriated to Singapore for cremation or burial)

☐ Cremation/burial permit (if cremation or burial occurred overseas)

☐ Copy of NRIC, birth certificate or passport of claimant(s)

☐ Proof of claimant's relationship with deceased

Claimant	Documents required
Spouse	Marriage Certificate
Parent	Birth Certificate of deceased
Child	Birth Certificate of claimant
Sibling	Birth Certificate of deceased and claimant

☐ Newspaper cutting and Outcome of police investigation report (if death was due to accident)

☐ Last Will of deceased (if deceased had left a Last Will)

☐ Employer's letter to certify the working hours of member on the date of accident

All documents submitted must be in English. Any documents in foreign languages must be officially translated to English by a certified translator/interpreter.

Payee's details

Benefits should be made payable to: ☐ Union/Association ☐ Claimant

Name of bank _____ Branch _____

Account number _____

Note: If you provide us with an inaccurate bank account number under this section for the payment of this claim, we shall discharge from all liability under this claim and not be liable for any losses incurred by you. (Please submit a copy of bank book or statement for account verification).

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

Beneficial Ownership Declaration - *This is NOT a nomination of beneficiaries of this policy*

A Beneficial Owner is defined in the MAS Notice on Prevention of Money Laundering and Countering the Financing of Terrorism as an individual who ultimately owns or controls the customer or the individual on whose behalf business relations are established.

If there is a Beneficial Ownership Arrangement, please

1. Please submit a copy of their NRIC or passport and a completed copy of the FATCA and CRS self-certification form for Individual Account Holder, Entity Account Holder or Controlling Person available here: www.income.com.sg/Policy-downloads-and-forms; and
2. Provide details below:

Name of Beneficial Owner	NRIC/Passport number/FIN	Date of birth (dd/mm/yyyy)
Nationality	**Gender**	**Relationship to Proposer**
☐ Singaporean ☐ Singapore PR (Nationality) _____ ☐ Others _____	☐ Male ☐ Female	

Personal data collection statement (A photocopy of this authorisation 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

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.

Signature of claimant	Date (dd/mm/yyyy)

For Official Use Only

To be completed by Union or Association		
Name of current ☐ Union ☐ Association	Date joined current Union or Association (dd/mm/yyyy)	
Name of first ☐ Union ☐ Association (if different from above)	Date joined first Union or Association (dd/mm/yyyy)	Continuous membership tenure _____ years _____ months
Membership type ☐ Ordinary branch ☐ General branch ☐ UClub ☐ UAssociate	Date of birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female

To be completed if member is/was a Union or Association leader (registered with RTU or LDIS)

Position in Union or Association	Served as Union or Association leader From (dd/mm/yyyy) _____ To (dd/mm/yyyy) _____

Note: Leaders must be holding office as at the date of death.

For members aged 65 years and above, please confirm whether member is covered under NTUC GIFT extension. ☐ Yes ☐ No

We certify that the information in this form is true and complete, that the above member/member's spouse* was eligible for the NTUC GIFT plan and the member was in our membership roll at the date of death of member/member's spouse*.

_____ _____

Name of authorised person | Signature of authorised person

Designation: President/General Secretary/Executive Secretary/
Treasurer [for OB members]/
Assistant Director/Deputy Director/Director,
NTUC Membership Dept [for GB/UClub/UAssociate members]*

_____ _____

Date (dd/mm/yyyy) | Union/Association stamp

* Delete where applicable

Instruction to Unions/Associations:

Please check that all required documents are attached to the claim form and email to **groupclaim@income.com.sg**.