

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 the claim is in respect of a dependant.

Group Policy No.		Name of Union			
Plan Type		Claim No.			
	Particular	s of Member			
Name of Member (Claimant)		Gender	NRIC No.		
		☐ Male ☐ Female			
Occupation		Date of Birth (dd/mm/yyyy)	Age		
Name of Dependant		Gender	NRIC No.		
		☐ Male ☐ Female			
Relationship to Member		Date of Birth (dd/mm/yyyy)	Age		
Address of Member					
Contact No.	41.)		Email		
(0)	(H) (Hp)				
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					
 I hereby declare that the above statements are true and complete and I have not withheld any material fact from NTUC Income. 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)		

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/09/2009