SLF GIFT/SLF GIFT PLUS*
NOTIFICATION OF
PERMANENT AND TOTAL DISABILITY CLAIM

To: LIFE CLAIMS DEPARTMENT
NTUC INCOME INSURANCE CO-OPERATIVE LTD
NTUC INCOME Centre, 75 Bras Basah Road Singapore 189557

1. Name of Union/Association*:

2. Particulars of Union/Association member

(a) Name : _____ (b) NRIC No.: _____

(c) Date & place of birth : _____ (d) Sex : Male ☐ Female ☐

(e) Address : _____

(f) Tel No : (O) _____ (H) _____ (g) Union/Association membership no.: _____

(h) Date joined Union/Association: _____ (i) Membership type : Ordinary/General * Branch Member

3. To be filled if member is a Union/Association Leader

(a) Position in Union/Association : Executive / Branch* Committee Member / _____(Please specify)

(b) Date elected as Union / Association leader : _____

3.1 To be filled if claim is for spouse (Please attach marriage certificate as proof of relationship)

(a) Name of spouse : _____ (b) NRIC No.: _____

(c) Date and place of birth : _____

4. Details of occupation

	Before Disability	After Disability
(a) Occupation	_____	_____
(b) Name of Employer	_____	_____
(c) Average monthly income	_____	_____
(d) List exact duties	_____	_____
performed at work	_____	_____
[see Note (i)]	_____	_____

Note: i) If you are not working, please provide a list of daily activities before and after disability
ii) NTUC INCOME reserves the right to request for documentary evidence

5. Details of disability

(a) Is the disability suffered due to :

☐ illness (date symptoms started _____)

☐ accident (date/time of accident _____)

(b) Describe in detail the disability suffered

_____

* Delete where applicable

(c) Date you last work _____

(d) Are you currently confined to:
☐ bed ☐ house
☐ neither

(e) Date you returned to work
_____
OR Date you expect to return to work
_____

6. Details of Doctor(s) consulted or Hospital(s) admission for this disability

Name(s)	Address(es)	Admission Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Details of your regular doctor or any other doctor(s) consulted for any other medical conditions

Name(s)	Address(es)	Admission Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. Other Claims

Are you claiming from any other insurance company or other sources in respect of this disability?
If yes, please provide the following information:

Name of Company	Policy No. (If applicable)
_____	_____
_____	_____

I hereby declare that the statements and answers given above are true and correct and I have not withheld any material fact from NTUC Income. I consent to NTUC Income obtaining medical information from any doctor I have consulted and I authorize the giving of such information. I agree that a photocopy of this form shall be as valid as the original.

Signature of Member : _____ Date : _____

Signature of Spouse : _____ Date : _____
(To be completed only if claim is for spouse)

<u>To be completed by Union / Association</u>

We hereby verify that the statements given are true and complete, that the above member/member's spouse* is eligible for the SLF GIFT/SLF GIFT Plus* scheme and the member was in our membership roll at the date of member's /member's spouse's disability.

Name : _____ Signature : _____

Designation: President/General Secretary/Executive/Treasurer/
Director, NTUC Membership Dept (for GB members)*

Date: _____ Union/Association stamp: _____

* Delete where applicable