INCOME

NTUC INCOME INSURANCE CO-OPERATIVE LIMITED
(ESTABLISHED IN 1970 UNDER THE CO-OPERATIVE SOCIETIES ACT SINGAPORE)

MAIN OFFICE: 75 BRAS BASAH ROAD • NTUC INCOME CENTRE • SINGAPORE 189557
TEL: 336 3322 • FAX: 338 1500 • TELEX: RS26261 • INTERNET ADDRESS:http://www.income.com.sg.

GROUP INSURANCE
NOTIFICATION OF TOTAL AND PERMANENT DISABILITY

(to be completed by the Insured)

The insurer does not admit liability by the mere issue of this form.

1. Name & branch of union

2. Particulars of union member

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

(c) Date & place of birth: _____ (d) Sex: ☐ M ☐ F

(e) Address: _____ Tel (O): _____

_____ Tel (H): _____

3. 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 the disability

ii) The Co-operative reserves the right to request for documentary evidence

4. 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

_____

_____

(c) Date you last worked	(d) Are you currently confined to:	(e) Date you returned to work
_____	☐ bed ☐ house ☐ neither	_____ OR Date you expect to return to work _____

5. Details of Physician(s) consulted or Hospital(s) admitted for this disability

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

6. Details of your regular physician or any other physician(s) consulted for any other disorders in the past three years

Name(s)	Address(es)	Reason for consultation
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Other claims

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

Name of company	Amount claimed	Policy No. (if applicable)
_____	_____	_____
_____	_____	_____
_____	_____	_____

To be completed by union

We hereby verify that the statements given are true and complete, that the above member was eligible for the scheme and was included in the last return of members made to the Society and was in our membership roll at the date of disability.

Signature _____ Name _____

Designation _____ Date _____

* Delete where applicable