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CHECKLIST FOR TOTAL AND PERMANENT DISABILITY CLAIM

Dear Claimant

We are sorry to learn of your injury. In order for us to process your claim, please complete this form in FULL and attach the following documents:

Important Notes

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

(b) Upon receipt of ALL the required documents, we will process your claim and inform you of the outcome as soon as possible. For each item provided, please tick (√) if applicable.

(c) Please submit all claim documents through your respective union upon verification.

☐ Total and Permanent Disability Claim Form (to be completed by Claimant)

☐ Attending Physician's Statement (APS) (to be completed by attending physician and submitted to us)

☐ Medical reports/Laboratory reports/Hospital Discharge Summary

☐ Medically boarded out letter (where applicable)

☐ Newspaper Cutting and Police/Accident Report (if Total and Permanent Disability was due to accident)

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TOTAL AND PERMANENT DISABILITY 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 Claimant. To avoid delay in processing your claim, please submit the duly completed claim form together with the supporting documents within 90 days from date of occurrence.

Particulars of Union/Association Member

Name of current ☐ Union ☐ Association	Date joined current Union/Association (dd/mm/yyyy)
Name of first ☐ Union ☐ Association (if different from above)	Date joined first Union/Association (dd/mm/yyyy)

Name of Member (as shown in NRIC/Passport/FIN)	NRIC/Passport/FIN No.

Membership type ☐ Ordinary ☐ General Branch Member ☐ UClub	Date of birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female

Address of Member

Contact No. (O) (Hp) (H)	Email

To be completed if member is a Union/Association leader

Position in Union/Association	Date elected as Union/Association leader (dd/mm/yyyy)

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

Name of Spouse	NRIC/Passport/FIN No.	Date of birth (dd/mm/yyyy)

Details of Occupation

	Before Disability	**After Disability**
Occupation		
Name of Employer		
Average monthly income		
List exact duties performed at work (If you are not working, please provide a list of daily activities before and after disability)		

NTUC INCOME reserves the right to request for documentary evidence related to **Details of Occupation**.

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Details of Disability

Disability suffered due to:

☐ Illness

Diagnosis ______________________ Date symptoms started ______________ (dd/mm/yyyy)

☐ Accident

Date of accident ______________ (dd/mm/yyyy) Time of accident ______________

Place of accident ______________________

Did the Insured report for work on date of accident? ☐ Yes ☐ No

Did the accident occur during working hours of the Insured? ☐ Yes ☐ No

Current Employment status ☐ Employed ☐ Unemployed

Date last worked (dd/mm/yyyy)

You are currently confined to

☐ bed ☐ house ☐ hospital ☐ N.A.

Date you returned/expect to return to work (dd/mm/yyyy)

Describe in detail the disability suffered

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

Name of Doctor	Name and Address of Clinic/Hospital	Date(s) of consultation (dd/mm/yyyy)	Date(s) of Admission (dd/mm/yyyy)

Details of your regular/company doctor or any other doctor(s) consulted for any other medical conditions

Name of Doctor	Name and Address of Clinic/Hospital	Date(s) of consultation (dd/mm/yyyy)	Reason(s) for consultation

Other Claims

Is the Member/Spouse claiming from any other insurance company (ies) or other sources (employer, other medical insurances, Workmen's Compensation Act) in respect of this condition/injury? If "Yes", please provide the following information. ☐ Yes ☐ No

Name of Employer, Insurance Company etc.	Policy No.	Date of Issue	Type of Plan	Claim Amount	Claim Notified (Yes/No)	Claim Paid (Yes/No)

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Declaration

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 any relevant information concerning the member/member's spouse 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

Date (dd/mm/yyyy)

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

Date (dd/mm/yyyy)

To be completed by Union/Association

For members exceeding age 65, please confirm whether member is under NTUC GIFT Extension. ☐ Yes ☐ No

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

Name of authorised person

Signature of authorised person

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

Date (dd/mm/yyyy)

Union/Association stamp

* Delete where applicable