NTUC INCOME

GROUP HOSPITALISATION BENEFIT CLAIM FORM

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.

Personal Particulars

Name of Member (Claimant)	Gender ☐ Female ☐ Male	NRIC No.
Occupation	Date of Birth	Age
Name of Dependant	Gender ☐ Female ☐ Male	NRIC No.
Relationship to Member	Date of Birth	Age
Address of Member		
Contact No. (H) (O) (HP)		Email

Details of Hospitalisation

1. Hospital Admitted to: _____

2. Admitted on (dd / mm / yyyy): _____ / _____ / _____

   Discharged on (dd / mm / yyyy): _____ / _____ / _____

3. Nature of Injury or Illness

I hereby declare that the above statements are true and complete and I have not withheld any material fact from NTUC Income. I consent to NTUC Income obtaining / providing information about me / my dependant from / to any medical source, insurance office, organisation or person. I agree that a photocopy of this form shall be as valid as the original.

Signature of Member (Claimant)	Date (dd/mm/yyyy)

Certification 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 abovenamed 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 Only

Claim No.	Next Premium Due Date	Signature of Officer(s)	Remarks
Hospital benefit per day	Amount ($)		
No. of hospital days	Amount ($)		
Please pay	Total ($)	Date	

GH-GLC/GHBCF/03/2009

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