

**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 <input type="checkbox"/> Female <input type="checkbox"/>		
(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 : _____		
(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)]	_____	_____
<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</i>		
5. Details of disability		
(a) Is the disability suffered due to :		
<input type="checkbox"/> 1. illness (date symptoms started _____)		
<input type="checkbox"/> 2. 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 _____

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)	Reason for consultation
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 authorise 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)

To be completed by Union/Association

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 Secretary/ Treasurer/
Director, NTUC Membership Dept (for GB members) *

Date : _____ Union/Association stamp : _____

* Delete where applicable