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REQUEST FOR LETTER OF GUARANTEE FORM (LOG)

(This form is not an admission of liability)

Patient Name:		PP/NRIC No.:	
Date of Birth:		Nationality:	
Date of Hire (for employee):		Policy No.:	4000132305 (Local) / 4000132314 (Intl)
Admission Date:		Place/Hospital:	
Discharge Date:		Treating Doctor:	

PATIENT STATEMENT AND CONSENT *(This section is to be completed by patient)*	
1. Description of Symptoms:	
2. Medical Condition (if known):	
3. Related medical history:	
4. Is this your first claim on this condition?	Yes / No*
5. Date you first aware of symptoms	(dd/mm/yyyy)
6. Date you first seek medical attention	(dd/mm/yyyy)
7. Name of your regular doctor and clinic address:	
8. Is this condition related to: a) Pre-existing / congenital? b) Infertility or pregnancy? c) Self-inflicted injury? d) Alcohol or drug abuse? e) Accident related? f) Routine check up?	*Please circle Yes / No* Yes / No Yes / No Yes / No Yes / No Yes / No If Yes, please specify: ……
9. Ward type and Estimate Cost:	Room type: _____ Estimate Length of Stay: _____ (Day) Hospital cost: _____ Doctor cost: _____
10. Are you covered under another insurance policy? If yes:	Insurer: Policy No: Type of Policy:

UNDERTAKING & CONSENT FROM PATIENT / PATIENT'S NEXT-OF-KIN:

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You may make your request to withdraw your consent, access or correct your personal data by writing to: The Data Protection Officer, NTUC Income Centre, 75 Bras Basah Road, Singapore 189557. Alternatively, you can email to: DPO@income.com.sg

I, _____ (Name) _____(NRIC/PP No), hereby give my consent and authorize the doctor(s), clinic(s), hospital(s) or any person who has attended to or examined me or is authorised to maintain my medical record to furnish and release my medical report to the 'Income Insurance Limited' (Insurer), its appointed administrator, and its staff and associates with respect to any of my illnesses or injuries, medical history, consultations, prescriptions or treatment.
By providing the information set out above, I agree and consent to Income Insurance Limited, its related corporations (collectively, the "Companies"), as well as their respective representatives and agents ("Representatives") collecting, using, disclosing and sharing amongst themselves my personal data, and disclosing such personal data to the Companies' authorised service providers and relevant third parties for purposes reasonably required by the Companies to evaluate, admit, process and/or settle my claims.
I also agree to the Insurer or Company seeking information from any source and I authorise the giving of such information. A photocopy of this authorisation is as valid as the original.

_____ _____
Signature of Patient / Next of Kin (state relationship) Date
Email Contact / HP No. _____