Student Internship Insurance Claim Form

(For Students)

Important notes

The acceptance of this form is NOT an admission of liability on the part of Insurer. Any documentary proof or report required by Insurer must be given at the expense of the policyholder or claimant. Please submit the completed claim form together with supporting documents within 30 days from the date of accident.

Please ensure that all sections of the claim form are completed, incomplete form will be returned to you for completion.

Supporting documents for the type of claim (please tick accordingly)

Medical Expenses:

- ☐ Final tax invoice(s)/receipt(s)
- ☐ Referral letter, test reports, A&E visit summary, doctor's memo stating diagnosis & cause etc, if applicable
- ☐ Police report, if applicable
- ☐ For hospitalisation/day surgery, a copy of Inpatient discharge summary/Day surgery form/attending physician's medical report
- ☐ Shield Plan's settlement letter if there is any payment by Medisave-approved Integrated Shield Plan

Permanent and Total/Partial Disability:

- ☐ Medical reports/Laboratory reports/Hospital Discharge Summary
- ☐ NRIC or relevant identification documents (e.g. passports, birth certificates) of claimant
- ☐ Accident report from school/centre
- ☐ Newspaper Clipping and Police Report

Please email the completed claim form and required documents to:
- corporate@rvc.com.sg

Particulars of Insured

Full Name (as shown in NRIC, FIN or BC)	NRIC, FIN or BC number	Gender ☐ Male ☐ Female
Date of birth (dd/mm/yyyy)	Nationality	Class
Residential address	Contact details (Mobile) (Home) (Email)	

If your contact particulars (i.e. address, contact number and email) indicated in this form are different from your existing records with us, we will not update all your existing policies with the new contact particulars.

Details of accident

Date and time of accident	Place of accident
Did the accident occur during supervised CCA? ☐ Yes ☐ No If 'Yes', please state the type of CCA: _____	Did the accident occur during organised school activities? ☐ Yes ☐ No
Describe how the accident happened.	
Describe the injuries sustained and the part(s) of the body injured.	

Other information

Have you claimed or do you intend to claim from any insurer, other employer or any other parties for reimbursement of your medical bills? If 'yes', please state the party that you are claiming from and submit a copy of the settlement letter or payment voucher from the other party. Note: It is important that you inform us if you are claiming from another insurer, other employer or any other parties for the same bill. You can only claim or be reimbursed once for the amount that you have incurred, regardless of the number of medical insurance policies you may have. We reserve the right to recover if there is any excess amount paid to you.	☐ Yes ☐ No

RVC

Payee's details (STUDENT)

Name of payee (as shown in the bank account)	NRIC, FIN, Passport or UEN number (as shown in the bank account)	Relationship to the insured	Nationality	Country of residence

Note: If payment is to be made to the parent, a copy of the student's birth certificate is required as proof of relationship.

Payment options:

☐ **PAYNOW (RECOMMENDED)**

- PayNow account must be registered with NRIC, FIN or UEN.
- PayNow account registered with mobile number or Trust Bank **will not** be applicable.

☐ **DIRECT CREDIT**

- It must be a Singapore bank account denominated in Singapore Dollar.
- It is compulsory to submit a copy of bank book/statement for verification purpose.

Name of bank _____

Account number _____

Declaration and authorisation by Insured

I certify that the information in this form is true and complete and I have not withheld any material information.

I confirm that I understand and agree to the collection, use and disclosure of my personal data as stated in the 'Personal Data Use Statement'(PDUS) above.

For the purposes of policy administration including processing and investigating this claim, and deciding whether Income is to insure or continue to insure me for my insurance applications or policies,

a. I authorise any person or organisation who has relevant information pertaining to this claim, including any medical practitioner, health care provider or institution, insurance company, and investigative agencies, to release and exchange such information (including personal health information) requested by Income and/or its claims service providers.

b. I authorise Income and its claims service providers to collect, use, disclose and to exchange with the persons or organisations listed above any information (including personal health information).

c. I am authorised to disclose information (including personal health information) about the insured person if this claim is made on behalf of them.

I confirm that all documents submitted to Income including bills and invoices are copy of the original documents and I am aware that I am required to retain all original documents for a period of 6 months from claim submission date for verification by Income when required. I am aware that Income may reject my claim should it discover that the document(s) that I have submitted is not a copy of the original document(s).

I confirm that I have paid in full all the bill(s)/invoice(s) that I have submitted to Income for reimbursement and I have not made any claim and will not make any claim from any other source for the same bill(s)/invoice(s). If I have made a claim from other source, I agree that I will provide a copy of the settlement agreement between me and such other source. I am aware that Income will not reimburse me if I have received a full reimbursement from any other source. If I do not receive full reimbursement from other source, I am aware and understand that Income will only reimburse me the balance of the bill/invoice that has not been paid to me by other source. In the event Income has made a reimbursement to me and I have claimed from other sources and be reimbursed for more than what I incurred in total, I agree that Income has the right to recover any payment made by Income to me.

I agree that a photocopy or electronic version of this authorisation shall be as valid as the original.

Name of Insured	Signature of Insured	Date (dd/mm/yyyy)