

FEMALE BENEFIT CLAIM FORM

(PRUSMART LADY, PRULADY, PRUFIRST GIFT, PRUFIRST PROMISE)

Important Notes

1. Please note that, under the policy terms and condition, the policy may be void if any information provided in this claim form are made knowingly by you that it is materially false or misleading.
2. The issue of this form is in no way an admission of liability. No claim can be considered unless the medical specialist report section is furnished at the expense of the claimant.
3. The Company reserves the rights to request for additional documents when deemed necessary.

PART I

(To be completed by the Life Assured who is at least 18 years old or the Policyowner if the Life Assured is below 18 years old)

1. DETAILS OF POLICY

Policy Number(s) of the benefit(s) you would like to claim:

2. DETAILS OF LIFE ASSURED

| | | | |
|---------------|--------------|-------------|--|
| Full Name | | NRIC No. | |
| Address | | Contact No. | |
| Date of birth | (DD/MM/YYYY) | Occupation | |

3. TYPE OF CLAIM

3.1 Please tick the appropriate box for the Female Illness / Medical Conditions you are claiming.

| PREGNANCY COMPLICATIONS | | PREGNANCY COMPLICATIONS | | PREGNANCY COMPLICATIONS | |
|---|--|--|--|--|--|
| Disseminated Intravascular Coagulation | | Fatty Liver of Pregnancy | | HELLP syndrome | |
| Ectopic pregnancy | | Postpartum Hemorrhage requiring Hysterectomy | | Amniotic Fluid Embolism | |
| Death of foetus after 195 days of pregnancy | | Miscarriage due to accident | | Abruptio Placentae | |
| Death of child within 28 days after birth | | Anterpartum Hemorrhage | | Psychiatrist / Psychologist consultation | |
| Death of life assured during delivery | | Gestational Diabetes Mellitus | | Vasa Previa | |
| Hydatidiform Mole | | Still Birth | | Termination of Pregnancy due to Life Threatening Condition | |
| Pre-Eclampsia or Eclampsia | | Placenta Increta/ Pecteta | | Antepartum and Intrapartum Haemorrhage | |
| Post-partum depression | | Uterine rupture | | Incompetent Cervix leading to Preterm birth | |

4. NATURE OF CLAIM

4.1 Please describe fully the extent and nature of illness.

4.2 Have you previously suffered from or received treatment for a similar or related illness / injury? If yes, please give details.

4.3 Please provide the details of all the doctors who had attended to you:-

| Name of doctor consulted | Address of doctor | Date first consulted for this illness |
|--------------------------|-------------------|---------------------------------------|
| | | |
| | | |
| | | |

4.4 Please provide the details of your regular doctor and company doctor whom you have consulted for minor ailments (e.g. flu, cough, fever), high blood pressure, high cholesterol, diabetes etc.:

| Name of doctor | Name and address of clinic/hospital | Dates of consultation (DD/MM/YYYY) | Reason(s) for consultation |
|----------------|-------------------------------------|------------------------------------|----------------------------|
| | | | |

5. OTHER INSURANCE

5 Are you insured for similar benefits with any other company? If yes, please give full details :-

| Name of Insurer | Type of Plan | Date of Issue | Benefit Amount |
|-----------------|--------------|---------------|----------------|
| | | | |
| | | | |

6. PAYMENT METHOD FOR CLAIM SETTLEMENT

PayNow (Default Payment Method)
 Any amount payable (if any) can only be made to the Policy Owner and will be paid via transfer to your **PayNow NRIC/FIN ID** by default. Please ensure that you have signed up for PayNow with your bank by linking it to your **NRIC/FIN**. Terms and conditions apply (<https://www.prudential.com.sg/PN-tnc>).

To register for PayNow.
 Log in to your bank's internet or mobile banking account > Sign up for PayNow > Link your PayNow to your NRIC/FIN.

*Cheque will be issued for Policy Owners who do not have a valid Singapore NRIC/FIN or have opted out of PayNow as default in PRUaccess; payout recipient who is not the Policy Owner and Corporate entities.

Direct Credit (Application Required)
 If you do not wish to receive payment via PayNow (NRIC/FIN), you may choose to receive payments via direct transfer to the Policy Owner's bank account.

Please fill in your bank details below and **submit** a copy of the policyowner's bank book or bank statement, stating the account holder's name and account number. We accept bank statements with the bank balances and transactions being blacked out, and truncated e-statements downloaded from the banks' mobile application, provided that the document shows the account holder's name and account number on the same page.

| Name of Account Holder | Name of Bank | Bank Account Number |
|------------------------|--------------|---------------------|
| | | |

Name of Life Assured:

NRIC / Passport No. of Life Assured:

DECLARATION

1. I understand and agree that the submission of this form does not mean that my request will be processed. I understand that any payout under the policy shall be strictly in accordance with the policy terms and conditions.
2. I hereby declare that the information that is disclosed on this form is to the best of my knowledge and belief, true, complete and accurate, and that no material information has been withheld or is any relevant circumstances omitted. I further acknowledge and accept that Prudential Assurance Company Singapore (Pte) Limited ("**PACS**") shall be at liberty to deny liability or recover amounts paid, whether wholly or partially, if any of the information disclosed on this form is incomplete, untrue or incorrect in any respect or if the Policy does not provide cover on which such claim is made.
3. I hereby warrant and represent that I have been properly authorised by the policyowner and the applicable insured(s) to submit information pertaining to such insured's claims.
4. I acknowledge and accept that the furnishing of this form, or any other forms supplemental thereto, by PACS, is neither an admission that there was any insurance in force on the life in question, nor an admission of liability nor a waiver of any of its rights and defenses.
5. I acknowledge and accept that PACS expressly reserves its rights to require or obtain further information and documentation as it deems necessary.
6. I confirm that I have paid in full all the bill(s)/invoice(s)/receipt(s) that I have submitted to PACS for reimbursement and have not claimed and do not intend to claim from other company(ies)/person(s).
7. I agree to produce all original bill(s)/invoice(s)/receipt(s) that were submitted for reimbursement to PACS for verification as it deems necessary.
8. For the purposes of (i) assessing, processing and/or investigating my claim(s) arising under the Policy or any of my other polic(ies) of insurance with PACS and such other purposes ancillary or related to the assessing, processing and/or investigating of such claim(s); (ii) administering the Policy, (iii) customer servicing, statistical analysis, conducting customer due diligence, reporting to regulatory or supervisory authorities, auditing and recovery of any debts owing to PACS whether in relation to the Policy or any of my other polic(ies) of insurance with PACS, (iv) storage and retention, (v) meeting requirements of prevailing internal policies of PACS, and/or (vi) as set out in PACS Privacy Notice ("**Purpose**"), I authorise, agree and consent to:
 - a. Any person(s) or organisation(s) that has relevant information concerning the policyowner and the insured person(s) (including any medical practitioner, medical/healthcare provider, financial service providers, insurance offices, government authorities/regulators, statutory boards, employer, or investigative agencies) ("**Person(s)/Organisation(s)**"), to disclose, release, transfer and exchange any information with PACS and its related corporations, respective representatives, agents, third party service providers, contractors and/or appointed distribution/business partners (collectively referred to as "**Prudential**"), including without limitation, personal data, medical information, medical history, employment and financial information, including the taking of copies of such records; and
 - b. Prudential collecting, using, disclosing, releasing, transferring and exchanging personal data about me, the policyowner and the insured person(s), with the Person(s)/Organisation(s), PACS's related group of companies, third party service providers, insurers, reinsurers, suppliers, intermediaries, lawyers/law firms, other financial institutions, law enforcement authorities, dispute resolution centres, debt collection agencies, loss adjustors or other third parties for the Purpose.
9. Where any personal data ("**3rd Party Personal Data**") relating to another person ("**Individual**") (including without limitation, insured persons, family members, and beneficiaries) is disclosed by me or permitted by me to be disclosed in accordance with Clause 8 above, I represent and warrant that I have obtained the consent of the Individual for Prudential to collect and use the 3rd Party Personal Data and to disclose the 3rd Party Personal Data to the persons enumerated above, whether in Singapore or elsewhere, for the Purpose stated above and in PACS Privacy Notice.
10. I understand that I can refer to PACS Privacy Notice, which is available at <https://www.prudential.com.sg/Privacy-Notice> for more information on contacting PACS for Feedback, Access, Correction and Withdrawal of using my/our personal data.

I understand that if I am an European Union ("**EU**") resident individual (i.e. my residential address is based in any of the EU countries), I can refer to PACS Privacy Notice for more information on the rights available to me under the GDPR.
11. I agree to indemnify Prudential for all losses and damages that Prudential may suffer in the event that I am in breach of any representation and warranty provided to me herein.
12. I agree to receive communication on the claim by email, SMS and/or hard copies by post.
13. I agree that this (i) Prudential shall have full access to the information stated in this form, and (ii) this authorisation and declaration shall form part of my proposed application for the relevant insurance benefits, and a photocopy of this form shall be treated as valid and binding as if it were the original.

Date and signature of Life Assured
(Policyowner to sign if Life Assured is below age 18 years)

Date and signature of Policyowner

Name of Life Assured:

NRIC / Passport No. of Life Assured:

PART II MEDICAL SPECIALIST REPORT

This section is to be completed by the life assured's attending medical specialist.

| | | | |
|---|----------|---------------------------------|-------|
| Name of Specialist | | MCR No. | |
| Field of Specialty | | | |
| Name of Medical Institution | | | |
| SECTION 1 | | | |
| 1. Are you the insured's usual doctor? | Yes / No | | |
| 2. Over what period do your records extend? | | | |
| Start date: _____ (DD/MM/YYYY) | | End date: _____ (DD/MM/YYYY) | |
| 3. Date you were first consulted for the condition | | DD | MM YY |
| 4. What were the presenting symptoms when you first saw the patient? | | | |
| | | | |
| 5. When did the above symptoms first started? | | DD | MM YY |
| If the date is unknown, please state how long the symptoms had been present prior to the date of first consultation. | | | |
| 6. What was the diagnosis? | | | |
| | | | |
| 7. Date of diagnosis | | DD | MM YY |
| 8. Date diagnosis was made known to the patient | | DD | MM YY |
| 9. What was the exact information regarding the diagnosis that the patient or patient's next of kin was informed on the date stated in (7) above. | | | |
| | | | |

| | |
|---|------|
| Signature & Practice Stamp of the Medical Specialist who filled up Part II | Date |
|---|------|

Name of Patient:

NRIC / Passport No. of Patient:

10. If you are not the first doctor who diagnosed the patient with this condition, please provide:
a. Name and practice address of the doctor who first made the diagnosis and had treated the patient for this condition.

b. Date the diagnosis was made by the previous doctor.

c. If the patient was referred to you for further management, please provide the name and practice address of the referral doctor. Please provide a copy of the referral letter.

11. What medical treatment has the patient been receiving? When did each of the treatment commence?

12. Please provide the name and address of the patient's regular attending doctor.

13. What is the patient's prognosis?

SECTION 2

**Please complete Question 1 to 4 if patient's condition is on:
Disseminated Intravascular Coagulation (DIC)**

| | | |
|--|-----|----|
| 1. Did DIC occur as a result of pregnancy? | Yes | No |
|--|-----|----|

| | | |
|--|-----|----|
| 2. Did DIC occur within first 7 months of pregnancy? | Yes | No |
|--|-----|----|

Signature & Practice Stamp of the Medical Specialist who filled up **Part II**

Date

Name of Patient:

NRIC / Passport No. of Patient:

| | | |
|--|-----|----|
| 3. Please state if the following were present: | | |
| - Entrance of uterine material with tissue factor activity into the maternal circulation | Yes | No |
| - Major hemorrhage | Yes | No |
| - End organ damage as a result of DIC | Yes | No |
| - Significant thrombocytopenia, pro-coagulant activation, fibrinolytic activation and inhibitor consumption | Yes | No |
| - Treatment with frozen plasma and platelet concentrates | Yes | No |
| 4. Was the patient admitted to hospital within 42 days after childbirth? If yes, please state the period of confinement: _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY) | Yes | No |
| Please complete Question 5 to 7 if the patient's condition is on: Ectopic Pregnancy | | |
| 5. Was there implantation of a fertilized ovum outside the uterine cavity? | Yes | No |
| 6. Was the ectopic pregnancy terminated by laparotomy or laparoscopic surgery? If no, please advise how the ectopic pregnancy was terminated. | Yes | No |
| 7. Was the patient admitted to hospital within 42 days after childbirth? If yes, please state the period of confinement: _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY) | Yes | No |

| | |
|---|------|
| Signature & Practice Stamp of the Medical Specialist who filled up Part II | Date |
|---|------|

Name of Patient:

NRIC / Passport No. of Patient:

| Please complete Question 8 to 10 if the patient's condition is on: Death of Foetus after 195 days of pregnancy | | |
|---|-----|----|
| 8. Was there death of foetus after 195 days of gestation? If yes, please the cause of death of the foetus. | Yes | No |
| 9. a. Was the foetus electively terminated or aborted? | Yes | No |
| b. If yes, was the termination required due to medical reasons? Please specify the reason for termination : | Yes | No |
| 10. Was the patient admitted to hospital within 42 days after childbirth? If yes, please state the period of confinement: _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY) | Yes | No |
| Please complete Question 11 to 12 if patient's condition is on: Death of child within 28 days after birth | | |
| 11. Was there death of child within 28 days of delivery? If yes, please state the cause of death of the child : | Yes | No |
| 12. Was the child alive at the time of delivery? | Yes | No |

| | |
|---|------|
| Signature & Practice Stamp of the Medical Specialist who filled up Part II | Date |
|---|------|

Name of Patient:

NRIC / Passport No. of Patient:

**Please complete Question 13 to 15 if the patient's condition is on:
Hydatidiform Mole**

13. Was the pregnancy characterized with the development of fluid-filled cysts in the uterus after the degeneration of the chorion?

Yes

No

14. Was there death of the embryo?

Yes

No

15. Was the patient admitted to hospital within 42 days after childbirth?
If yes, please state the period of confinement:

Yes

No

_____ to _____
(DD/MM/YYYY) (DD/MM/YYYY)

**Please complete Question 16 to 19 if patient's condition is on:
Pre-Eclampsia or Eclampsia**

16. Was there hypertension developing after 20 weeks of pregnancy?

Yes

No

17. Please provide 2 readings of the highest recorded blood pressure reading taken at least 6 hours apart.

Reading 1 & date taken

Reading 2 & date taken

18. Was there associated proteinuria of >3+ on random urine sample or >2.5g in a 24 hours urine specimen?

Yes

No

19. Was the patient admitted to hospital within 42 days after childbirth?
If yes, please state the period of confinement:

Yes

No

_____ to _____
(DD/MM/YYYY) (DD/MM/YYYY)

Signature & Practice Stamp of the Medical Specialist who filled up **Part II**

Date

Name of Patient:

NRIC / Passport No. of Patient:

**Please complete Question 20 to 24 if patient's condition is on:
Fatty Liver of Pregnancy**

20. Was there acute liver failure?

Yes

No

21. Was there persistent elevation of bilirubin above 150 umol/L (10 mg/dL) for a period of at least 5 days?

Yes

No

22. If yes, please state the readings taken each day?

Date: _____ Reading: _____

Date: _____ Reading: _____

Date: _____ Reading: _____

Date: _____ Reading: _____

Date: _____ Reading: _____

23. Was there associated hepatic encephalopathy?

Yes

No

24. Was the patient admitted to hospital within 42 days after childbirth?
If yes, please state the period of confinement

Yes

No

_____ to _____
(DD/MM/YYYY) (DD/MM/YYYY)

Signature & Practice Stamp of the Medical Specialist who filled up **Part II**

Date

Name of Patient:

NRIC / Passport No. of Patient:

**Please complete Question 25 to 26 if patient's condition is on:
Amniotic Fluid Embolism**

25. Please advise if the following were present:

- | | | | | |
|--|--------------------------|-----|--------------------------|----|
| a) Respiratory Distress | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| b) Cardiovascular Collapse | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| c) Disseminated Intravascular Coagulation | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| d) Coma | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| e) Pulmonary Embolism as evident on lung scans | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

26. Was the patient admitted to hospital within 42 days after childbirth?
If yes, please state the period of confinement

_____ to _____
(DD/MM/YYYY) (DD/MM/YYYY)

Yes

No

**Please complete Question 27 to 31 if patient's condition is on:
Abruptio Placentae**

27. When is the expected date of delivery?

(DD/MM/YYYY)

28. Did abruptio placentae occur after the 20th week of gestation and prior to birth of the foetus?

Yes

No

29. Was there life threatening fetal distress leading to maternal shock?

Yes

No

30. Were there Class 2 or Class 3 abruptio?

Yes

No

31. Was the Caesarian section performed an emergency or planned surgery?

Please state the date of the surgery

(DD/MM/YYYY)

Yes

No

Signature & Practice Stamp of the Medical Specialist who filled up **Part II**

Date

Name of Patient:

NRIC / Passport No. of Patient:

| Please complete Question 32 to 35 if patient's condition is on: Postpartum Hemorrhage requiring Hysterectomy | | |
|--|-------------------------------|----|
| 32. Please advise if there was ongoing bleeding following delivery. | Yes | No |
| 33. If yes, was the bleeding due to an unresponsive and atonic uterus, ruptured uterus or large cervical laceration extending into the uterus? | Yes | No |
| 34. Was hysterectomy performed as a result of the postpartum hemorrhage If yes, please provide a copy of the operation report/ notes. | Yes | No |
| 35. Was the patient admitted to hospital within 42 days after childbirth? If yes, please state the period of confinement _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY) | Yes | No |
| Please complete Questions 36 to 42 if patient's condition is on: Miscarriage due to Accident | | |
| 36. Please state the date of accident and describe how the accident happened. How the accident happened: | Accident date (DD/MM/YYYY) | |
| 37. Please provide a copy of the police statement of this accident. | | |
| 38. Please state if the accident has led to a miscarriage | Yes | No |
| 39. If yes, please state the date where the miscarriage took place. | (DD/MM/YYYY) | |
| 40. Please state the duration of the pregnancy at the time of miscarriage. | (number of weeks) | |

| | |
|---|------|
| Signature & Practice Stamp of the Medical Specialist who filled up Part II | Date |
|---|------|

Name of Patient:

NRIC / Passport No. of Patient:

| | | |
|--|-----|----|
| 41. Were there any causes other than the accident that may have caused the miscarriage? | Yes | No |
| a. If yes, please state the date of diagnosis of the condition stated in (Q41) _____ (DD/MM/YYYY) b. Name and address of the doctor who made the diagnosis: | | |
| 42. Was the patient admitted to hospital within 42 days after childbirth? If yes, please state the period of confinement _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY) | Yes | No |
| Please complete Question 43 to 47 if the patient's condition is on: Antepartum Hemorrhage | | |
| 43. Please state the underlying cause of the antepartum hemorrhage. | | |
| 44. Was there genital bleeding during pregnancy after 28 weeks of pregnancy? | Yes | No |
| 45. If yes, did the bleeding led to loss of foetus or hysterectomy? | Yes | No |
| 46. Was hysterectomy performed as a result of the antepartum hemorrhage? If yes, please provide a copy of the operation report/ notes. | Yes | No |
| 47. Was the patient admitted to hospital within 42 days after childbirth? If yes, please state the period of confinement _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY) | Yes | No |

| | |
|---|------|
| Signature & Practice Stamp of the Medical Specialist who filled up Part II | Date |
|---|------|

Name of Patient:

NRIC / Passport No. of Patient:

**Please complete Question 48 to 50 if the patient's condition is on:
Placenta Increta/ Percreta**

| | | |
|---|-----|----|
| 48. Was there abnormal adherent of the placenta to the myometrium. | Yes | No |
| 49. Was there presence of severe hemorrhage? | Yes | No |
| 50. Was a surgical removal of placenta done? If yes, please state the date of surgery. _____(DD/MM/YYYY) Please also provide a copy of the histology report and operation report. | Yes | No |

**Please complete Question 51 to 54 if the patient's condition is on:
Uterine Rupture**

| | | |
|--|-----|----|
| 51. Was there rupture of uterus during pregnancy or childbirth? | Yes | No |
| 52. If yes, did the rupture result in foetal death or hysterectomy? | Yes | No |
| 53. Was hysterectomy performed as a result of the uterine rupture? If yes, please provide a copy of the operation report/ notes. | Yes | No |
| 54. Was the patient admitted to hospital within 42 days after childbirth? If yes, please state the period of confinement _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY) | Yes | No |

**Please complete Question 55 to 57 if the patient's condition is on:
HELLP Syndrome**

| | | |
|--|------------------------------|-----------------------------|
| 55. Please advise if the following were present: | | |
| a) Haemolysis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) Elevated Liver Enzymes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) Low Platelets | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

| | |
|---|------|
| Signature & Practice Stamp of the Medical Specialist who filled up Part II | Date |
|---|------|

Name of Patient:

NRIC / Passport No. of Patient:

| | | | | | | | | | | | | | | | | | |
|--|--------------------------|-----------|--|--------------------------|-----|--------------------------|----|---|--------------------------|-----|--------------------------|----|--|--------------------------|-----|--------------------------|----|
| <p>56. Did the pregnancy complication result in foetal death? If yes, when did the death of foetus occur? _____ (DD/MM/YYYY)</p> | <p>Yes</p> | <p>No</p> | | | | | | | | | | | | | | | |
| <p>57. Was the patient admitted to hospital within 42 days after childbirth? If yes, please state the period of confinement _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)</p> | <p>Yes</p> | <p>No</p> | | | | | | | | | | | | | | | |
| <p>Please complete Question 58 to 71 if the patient's condition is on: Gestational diabetes mellitus</p> | | | | | | | | | | | | | | | | | |
| <p>58. Does the patient have gestational diabetes mellitus (GDM)? If yes, a) please state the date of diagnosis _____ (DD/MM/YYYY) b) how many weeks pregnant was the patient when she developed GDM _____</p> | <p>Yes</p> | <p>No</p> | | | | | | | | | | | | | | | |
| <p>59. Did the patient's GDM screening results meet any of the following values:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 70%;">a) Fasting plasma glucose 5.1 – 6.9 mmol/L</td> <td style="width: 5%; text-align: center;"><input type="checkbox"/></td> <td style="width: 15%;">Yes</td> <td style="width: 5%; text-align: center;"><input type="checkbox"/></td> <td style="width: 5%;">No</td> </tr> <tr> <td>b) 1-hr plasma glucose \geq 10.0 mmol/L following a 75g oral glucose load</td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Yes</td> <td style="text-align: center;"><input type="checkbox"/></td> <td>No</td> </tr> <tr> <td>c) 2-hr plasma glucose 8.5 – 11.0 mmol/L following a 75g oral glucose load</td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Yes</td> <td style="text-align: center;"><input type="checkbox"/></td> <td>No</td> </tr> </table> <p>Please provide copies of the GDM screening results.</p> | | | a) Fasting plasma glucose 5.1 – 6.9 mmol/L | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | b) 1-hr plasma glucose \geq 10.0 mmol/L following a 75g oral glucose load | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | c) 2-hr plasma glucose 8.5 – 11.0 mmol/L following a 75g oral glucose load | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| a) Fasting plasma glucose 5.1 – 6.9 mmol/L | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | |
| b) 1-hr plasma glucose \geq 10.0 mmol/L following a 75g oral glucose load | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | |
| c) 2-hr plasma glucose 8.5 – 11.0 mmol/L following a 75g oral glucose load | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | | | | | | | | | | | | | |
| <p>60. Did the patient give birth to a baby with foetal macrosomia? Please state the birth weight of the baby _____</p> | <p>Yes</p> | <p>No</p> | | | | | | | | | | | | | | | |
| <p>61. Did the baby have neonatal hypoglycaemia?</p> | <p>Yes</p> | <p>No</p> | | | | | | | | | | | | | | | |
| <p>62. Was the plasma glucose level less than 1.65 mmol/L (30 mg/dL) in the first 24 hours of life? Please state the plasma glucose level _____</p> | <p>Yes</p> | <p>No</p> | | | | | | | | | | | | | | | |

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|--|-------------|
| <p>Signature & Practice Stamp of the Medical Specialist who filled up Part II</p> | <p>Date</p> |
|--|-------------|

Name of Patient:

NRIC / Passport No. of Patient:

| | | |
|--|------------------------------|-----------------------------|
| 63. Did the GDM persist after delivery? | Yes | No |
| 64. When was the patient confirmed to have progressed to permanent diabetes? _____ (DD/MM/YYYY) | | |
| 65. Was the permanent diabetes a Type 1 or Type 2 diabetes? Type 1 / Type 2 (please circle the appropriate) | | |
| 66. Did the patient have any of the following: | | |
| a) Symptoms of diabetes mellitus | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) Random plasma glucose concentration of at least 200 mg/dL (11.1 mmol/L) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) Fasting plasma glucose level of at least 8 hrs of 126 mg/dL (7.0 mmol/L) or higher? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d) Two-hour plasma glucose level of 200 mg/dL or more during an oral glucose | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e) HbA1c above 6.5% | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 67. Were the above values tested at least twice? Please provide a copy of the laboratory reports | Yes | No |
| 68. Does the patient have any prior history of GDM, diabetes mellitus or impaired glucose tolerance prior to this pregnancy? | Yes | No |
| 69. If yes, please state the date of diagnosis and name and address of doctor who made the diagnosis. | | |
| a) Date of diagnosis: _____ (DD/MM/YYYY) | | |
| b) Diagnosis made: _____ | | |
| c) Name and address of doctor who made the diagnosis: _____ _____ | | |

| | |
|---|------|
| Signature & Practice Stamp of the Medical Specialist who filled up Part II | Date |
|---|------|

Name of Patient:

NRIC / Passport No. of Patient:

| | | |
|--|-----|----|
| 70. Did the patient develop any pregnancy complication during her pregnancy? If yes, please specify the complication: _____ | Yes | No |
| 71. Please state the date of diagnosis of the pregnancy complication. Date of diagnosis: _____ (DD/MM/YYYY) | | |
| Please complete Question 72 to 74 if the patient's condition is on: Still Birth | | |
| 72. Was there death of the baby after 28 weeks gestation? If yes, please state the cause of death of the baby: _____ | Yes | No |
| 73. Was the baby electively terminated or aborted? If yes, was the termination required due to medical reasons? Please specify the reason for termination: _____ | Yes | No |
| 74. Was the baby alive at the time of delivery? | Yes | No |
| Please complete Question 75 to 76 if the patient's condition is on: Psychiatrist/ Psychologist consultation | | |
| 75. Did the patient receive any psychological or psychiatric consultation during her pregnancy or post-delivery? If yes, please state the period which she received psychological or psychiatric consultation. _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY) | Yes | No |

| | |
|---|------|
| Signature & Practice Stamp of the Medical Specialist who filled up Part II | Date |
|---|------|

Name of Patient:

NRIC / Passport No. of Patient:

76. Why did the patient require psychological or psychiatric consultation?

Please provide:

- The diagnosis: _____ ; and
- Date of diagnosis: _____ (DD/MM/YYYY)

**Please complete Question 77 to 78 if the patient's condition is on:
Post-partum depression**

77. Did the patient suffer from postpartum depression?

Yes

No

78. When was the patient diagnosed to have postpartum depression?

Date of diagnosis: _____ (DD/MM/YYYY)

**Please complete Question 79 to 82 if the patient's condition is on:
Vasa Previa**

79. Did the foetal blood vessels cross or run near the internal opening of the uterus?

Yes

No

80. If yes, did this lead to a caesarean section?

Please state the date of the surgery: _____ (DD/MM/YYYY)

Yes

No

81. When was the patient diagnosed to have Vasa Previa?

Date of diagnosis: _____ (DD/MM/YYYY)

82. Was Vasa Previa established via transvaginal ultrasound evidence confirmed by a gynaecologist or obstetrician?

If yes, please provide a copy of the ultrasound report.

Yes

No

Signature & Practice Stamp of the Medical Specialist who filled up **Part II**

Date

**Please complete Question 83 to 86 if the patient's condition is on:
Termination of pregnancy due to a life-threatening condition**

| | | |
|--|----------------|--------------|
| 83. Did death of the foetus (unborn baby) occur after 13 weeks of pregnancy? | Yes | No |
| 84. Was the death of the foetus due to a sudden unforeseen and involuntary event? If yes, please specify the details of the sudden unforeseen and involuntary event: | Yes | No |
| 85. Was the death of the foetus due to termination of pregnancy as a direct consequence of a life-threatening condition of the life assured? If yes, was the termination required due to medical reasons? Please specify the reason for termination: | Yes Yes | No No |
| 86. Was the termination of pregnancy due to a voluntary or malicious act? | Yes | No |

**Please complete Question 87 to 90 if the patient's condition is on:
Antepartum and Intrapartum Haemorrhage**

| | | |
|--|-----|----|
| 87. Please state the underlying cause of the antepartum and intrapartum hemorrhage | | |
| 88. Was there severe bleeding from or into the female genital tract? | Yes | No |
| 89. If yes, did the bleeding occurred from 24 weeks of pregnancy until before the birth or during the birth of the baby? | Yes | No |
| 90. If yes, did the bleeding led to potentially life-threatening maternal or foetal complications? Please provide details on the complications. | Yes | No |

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| Signature & Practice Stamp of the Medical Specialist who filled up Part II | Date |
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**Please complete Question 91 to 92 if the patient's condition is on:
Incompetent cervix leading to preterm birth**

| | | |
|---|------------|-----------|
| <p>91. Was there incompetent cervix where weak cervical tissue causes an extremely preterm delivery before the completion of 31 weeks?</p> <p>If yes, please state the date of preterm delivery: _____(DD/MM/YYYY)</p> <p>What was the gestation period when the baby was born: _____ weeks</p> | <p>Yes</p> | <p>No</p> |
| <p>92. Was the diagnosis of incompetent cervix leading to preterm birth confirmed by an appropriate medical specialist using a vaginal ultrasound and with confirmation of the preterm delivery?</p> <p>If yes, please provide a copy of the ultrasound report/memo.</p> | <p>Yes</p> | <p>No</p> |

Please complete Question 93 on the patient's period of hospitalisation

| |
|---|
| <p>93. Please state the patient's period of hospitalisation. _____ to _____ DD/MM/YYYY DD/MM/YYYY</p> |
|---|

SECTION 3

| | | |
|---|---------------------|-----------|
| <p>1. Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?</p> | <p>Yes</p> | <p>No</p> |
| <p>If yes, please provide the date of diagnosis of HIV/ AIDS.</p> | <p>(DD/MM/YYYY)</p> | |
| <p>2. Is the diagnosis related to a deliberate act of taking intoxicating liquor, drugs or poison, suicide or attempted suicide or intentional self-injury</p> | <p>Yes</p> | <p>No</p> |
| <p>If yes, please provide details.</p> | | |
| <p>3. Is the diagnosis related to the use of unprescribed drugs where such drugs are required by law to be prescribed by a registered medical practitioner?</p> | <p>Yes</p> | <p>No</p> |
| <p>If yes, please provide details.</p> | | |

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| <p>Signature & Practice Stamp of the Medical Specialist who filled up Part II</p> | <p>Date</p> |
|--|-------------|

Name of Patient:

NRIC / Passport No. of Patient:

| | | |
|--|------------|-----------|
| <p>4. Was this pregnancy conceived via any fertility treatment? <i>(please tick as applicable)</i></p> <p>a) In-vitro fertilization (IVF) <input type="checkbox"/></p> <p>b) Intracytoplasmic sperm injection (ICSI) <input type="checkbox"/></p> <p>c) Intrauterine insemination (IUI) <input type="checkbox"/></p> <p>d) Intracervical insemination (ICI) <input type="checkbox"/></p> <p>e) Other: Please specify _____</p> <p>If yes, please state the number of foetus conceived: _____</p> | <p>Yes</p> | <p>No</p> |
| <p>5. Was the patient carrying 3 or more babies in a single pregnancy</p> | <p>Yes</p> | <p>No</p> |
| <p>SECTION 4</p> | | |
| <p>1. Has the patient's condition resulted in him/her to be physically or mentally disabled from ever continuing in any employment? If Yes, please state:</p> | <p>Yes</p> | <p>No</p> |
| <p>a. What were the patient's main physical or mental impairment and the severity of these limitations?</p> | | |
| <p>b. What is your reason that the patient is incapable of any employment throughout his/her lifetime?</p> | | |
| <p>c. In accordance to the Singapore's Mental Capacity Act (Cap 177A), is the patient mentally incapacitated?</p> | <p>Yes</p> | <p>No</p> |
| <p>2. Is the patient suffering from any significant medical condition? If yes, please provide the following information:</p> | <p>Yes</p> | <p>No</p> |
| <p>a) Date of diagnosis : _____ (DD/MM/YYYY)</p> <p>b) Name and practice address of the doctor who had diagnosed/ treated the patient.</p> | | |
| <p>3. Please provide details of the patient's personal medical history and any further information about the patient, which may be of assistance to us in assessing this claim?</p> | | |

| | |
|--|-------------|
| <p>Signature & Practice Stamp of the Medical Specialist who filled up Part II</p> | <p>Date</p> |
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PART III ATTACHMENT OF LABORATORY REPORTS

To enable us to proceed with the claim, it is mandatory to enclose all relevant clinical, radiological, histological, operation and laboratory reports by attaching them to this page.

Prudential Assurance Company Singapore (Pte) Limited
Postal Address: Robinson Road P.O. Box 492 Singapore 900942
Telephone: 6535 8988 Fax: 6734 9555 Website:
Part of Prudential Corporation plc Reg. No 199002477Z