

**CRISIS COVER CLAIM FORM
(COMA/ SEVERE EPILEPSY)****SECTION 1**

This section is 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

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.

Mandatory Required documents for claim submission:

1. Crisis Cover Claim Form and Medical Specialist Report (please select the appropriate form depending on the medical condition)
2. Clinical Abstract Application Form (3 copies)
3. Diagnostic laboratory and objective test reports supporting the diagnosis

Important Note: 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.

LIFE ASSURED'S PARTICULARS

Full Name	<input type="text"/>	NRIC No	<input type="text"/>
Address	<input type="text"/>		
Date of Birth	<input type="text"/>	Contact No	<input type="text"/>
Occupation	<input type="text"/>		

Method of Delivery for Claim Settlement:

- Mail Self Collection Delivery by a Prudential Financial Consultant
Name and Contact Number of Financial Consultant

POLICY DETAILS

Please indicate the policy number for the benefit type you would like to claim.

Benefit Type	Policy Number(s)
<input type="checkbox"/> Crisis Cover/ Crisis Cover Provider/ PruMultiple Crisis Cover / Crisis Waiver / Critical Illness Waiver	<input type="text"/>
<input type="checkbox"/> PruEarly Staged Crisis Cover	<input type="text"/>
<input type="checkbox"/> Terminal Illness	<input type="text"/>

DECLARATION

I hereby declare that all information given by me in this form are, to the best of my knowledge and belief, true and complete. I hereby authorise Prudential Assurance Company Singapore (Pte) Limited ("Prudential") to:

- a) seek medical information from any doctor who, at any time, has attended to the life assured concerning anything which affects his/her physical or mental health;
- b) seek information from any insurance office to which a insurance proposal has been made; and
- c) seek information from any other sources (including employer, government authorities) in connection with this claim.

I understand and agree that Prudential should have full access to the information stated above and a photographic copy of this authorisation shall be as valid as the original.

Name & Signature of Life Assured or Policyowner if
Life Assured is below 18 years old

Date

Prudential Assurance Company Singapore (Pte) Limited 30 Cecil Street #30-01 Prudential Tower Singapore 049712

Postal Address: Robinson Road P.O. Box 492 Singapore 900942

Telephone: 6535 8988 Fax: 6734 9555 Website: www.prudential.com.sg

Part of Prudential Corporation plc Reg. No 199002477Z

1. TYPE OF CLAIM

Please indicate the type of claim you would like to file by ticking the appropriate box

a) Critical Illness Benefit

For Crisis Cover/ Crisis Cover Provider/ Crisis Waiver/ Critical Illness Waiver / PruMultiple Crisis Cover/ PruEarly Staged Crisis Cover (Critical Illnesses)

- | | | |
|--|---|--|
| <input type="checkbox"/> Alzheimer's Disease/
Severe Dementia | <input type="checkbox"/> Aplastic
Anaemia | <input type="checkbox"/> Bacterial Meningitis |
| <input type="checkbox"/> Benign Brain Tumor | <input type="checkbox"/> Blindness (Loss of Sight) | <input type="checkbox"/> Coma |
| <input type="checkbox"/> Coronary Artery
By-Pass Surgery | <input type="checkbox"/> Deafness (Loss of
Hearing) | <input type="checkbox"/> Encephalitis |
| <input type="checkbox"/> End Stage Liver Failure | <input type="checkbox"/> End Stage Lung Disease | <input type="checkbox"/> Fulminant Hepatitis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Valve Surgery | <input type="checkbox"/> Kidney Failure |
| <input type="checkbox"/> HIV due to blood
Transfusion &
Occupationally
Acquired HIV | <input type="checkbox"/> Angioplasty and Other
Invasive Treatment for
Coronary Artery | <input type="checkbox"/> Major Burns |
| <input type="checkbox"/> Major Cancers | <input type="checkbox"/> Major Head Trauma | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Major Organ/ Bone
Marrow Transplant | <input type="checkbox"/> Motor Neurone
Disease | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Primary Pulmonary Disease | <input type="checkbox"/> Progressive Scleroderma |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Surgery to the Aorta | <input type="checkbox"/> Terminal Illness |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Apallic Syndrome |
| <input type="checkbox"/> Loss of Speech | | |

For PruEarly Staged Crisis Cover (Early Stage)

- | | | |
|--|--|--|
| <input type="checkbox"/> Moderately Severe
Alzheimer's Disease
or Dementia | <input type="checkbox"/> Reversible Aplastic
Anaemia | <input type="checkbox"/> Bacterial Meningitis
with full recovery |
| <input type="checkbox"/> Surgical removal of
Pituitary tumor or
Surgery for
Subdural Hematoma | <input type="checkbox"/> Loss of sight in one eye | <input type="checkbox"/> Coma for 48 hours |
| <input type="checkbox"/> Keyhole coronary bypass
surgery or Coronary
Artery Arthrectomy or
Transmyocardial Laser
Revascularisation or
Enhanced External
Counterpulsation
Device Insertion | <input type="checkbox"/> Partial loss of hearing
or Cavernous sinus
thrombosis surgery | <input type="checkbox"/> Encephalitis with
full recovery |
| <input type="checkbox"/> Liver Surgery | <input type="checkbox"/> Severe Asthma or
Insertion of a Veno-cava
filter | <input type="checkbox"/> Hepatitis with
Cirrhosis |
| <input type="checkbox"/> Cardiac Pacemaker
Insertion or
Pericardectomy | <input type="checkbox"/> Percutaneous Valve
Surgery | <input type="checkbox"/> HIV due to Assault, Organ
Transplant or Occupationally
Acquired HIV |
| <input type="checkbox"/> Surgical Removal
of one kidney | <input type="checkbox"/> Loss of Speech due
to neurological disease | <input type="checkbox"/> Moderately Severe
Burns |

- | | | |
|---|--|---|
| <input type="checkbox"/> Carcinoma in-situ of specified organs | <input type="checkbox"/> Facial reconstructive Surgery or Spinal cord surgery | <input type="checkbox"/> Small bowel Transplant or Corneal Transplant |
| <input type="checkbox"/> Early Multiple Sclerosis | <input type="checkbox"/> Early Motor Neurone Disease | <input type="checkbox"/> Moderately Severe Muscular Dystrophy |
| <input type="checkbox"/> Moderately severe Parkinson 's Disease | <input type="checkbox"/> Early Pulmonary Hypertension | <input type="checkbox"/> Early Progressive Scleroderma |
| <input type="checkbox"/> Brain aneurysm Surgery or Cerebral Shunt Insertion | <input type="checkbox"/> Minimally Invasive Surgery to Aorta or Large asymptomatic Aortic Aneurysm | |

For PruEarly Staged Crisis Cover (Intermediate Stage)

- | | | |
|---|---|--|
| <input type="checkbox"/> Optic Nerve Atrophy with low vision | <input type="checkbox"/> Severe Epilepsy or Coma for 72 hours | <input type="checkbox"/> Cochlear Implant Surgery |
| <input type="checkbox"/> Liver Cirrhosis | <input type="checkbox"/> Surgical removal of one Lung | <input type="checkbox"/> Cardiac Defibrillator Insertion or Early Cardiomyopathy |
| <input type="checkbox"/> Carcinoma in-situ of specified organs treated with Radical Surgery | <input type="checkbox"/> Secondary Pulmonary Hypertension | <input type="checkbox"/> Progressive Scleroderma with CREST syndrome |
| <input type="checkbox"/> Carotid artery surgery | | |

For PruEarly Staged Crisis Cover (Special benefit)

- | | |
|---|---|
| <input type="checkbox"/> Angioplasty and Other Invasive Treatment for Coronary Artery | <input type="checkbox"/> Diabetic Complications |
|---|---|

b) Terminal Illness Benefit

- Terminal Illness Benefit

2. NATURE OF CLAIM

2.1 Describe fully the extent and nature of illness/injury. If your condition is caused by an accident, please provide the date of the accident and describe how and where did the accident occur.

2.2 Was a police report made? Yes No If yes, please attach a copy of the report.

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

2.4 Please provide the details of all doctors or specialists whom you have consulted in connection with your illness/injury: -

Name of Doctor	Name and Address of Clinic/ Hospital	Dates of Consultation	Reason for Visit

2.5 Please provide details of your usual medical attendant if different from above: -

Name of Doctor	Name and Address of Clinic/ Hospital

3. GENERAL

3.1 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

3.2 Do you smoke cigarettes? Yes No
 If 'yes', please give full details: -

What is your daily consumption? sticks/ per day

For how long have you been smoking?

SECTION 2

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

MEDICAL SPECIALIST REPORT (COMA/ SEVERE EPILEPSY)

Name of Specialist MCR No.

Field of Specialty

Name of Medical Institution

PART I

1. When were you first consulted for the condition?

	DD		MM		YY
--	----	--	----	--	----

2a. What were the presenting symptoms when you first saw the patient?

2b. When did the above symptoms first present?

	DD		MM		YY
--	----	--	----	--	----

If the date is unknown, please state how long the symptoms had been present prior to the date of first consultation.

3a. Please provide full and exact details of the diagnosis.

3b. Date of diagnosis.

3c. Date the patient was informed of the diagnosis.

4. Please provide dates and details of investigation performed for the diagnosis. Kindly attach copies of all relevant objective test reports, which confirmed the diagnosis.

5a. Were you the doctor who **first** diagnosed the patient with this condition? Yes () No ()

5b. If yes, over what period do your record extend? From to

5c. If you are not the first doctor who diagnosed the patient with this condition, please provide:

(i) name and practice address of the doctor who first made the diagnosis or had treated the patient for this condition.

(ii) date the diagnosis was made by the previous doctor.

(iii) when was the referral made for the patient to see you?

PART II

This section is applicable for COMA only.

1. Please provide full and exact details of the injury, disease or condition causing coma, including date and time of onset.

2. How many hours was the patient in a state of coma, with no response to external stimuli?

3. Was the patient put on life support measures? Yes () No ()
If yes, please give details of the life support measures.

4. Please provide the date and time of emergence from the coma, with no response to external stimuli.

5. Was there any form of permanent neurological deficit assessed 30 days after the onset of the coma? Yes () No ()

If yes, please provide details of the neurological deficit.

6. If the coma was due to injury, is it a result of self-inflicted act? Yes () No ()

If yes, please provide details.

7. Did coma result directly from alcohol, drug absence or medically induced coma? Yes () No ()

If yes, please provide details.

This section is applicable for EPILEPSY only.

1. How was the diagnosis of Epilepsy established? **Please include a copy of diagnostic reports (i.e. Electroencephalography (EEG), Magnetic Resonance Imaging (MRI), Position Emission Tomography (PET), or others)**

2. Has the patient experienced recurrent unprovoked tonic-clonic or grand mal seizures and be known to be resistant to optimal therapy as confirmed by drug serum level testing? Yes () No ()

If yes, please provide the following:

(i) Dates of attacks: _____

(ii) Frequency of such attacks per week: _____

3. Is the patient taking prescribed anti-epileptic (anti-convulsant) medications? Yes () No ()

If yes, please state the type(s) of medication and period he has been on such medication.

4. Would you consider the patient to be on optimal drug therapy? Yes () No ()

If yes, please state the period the patient has been on such anti-epileptic therapy.

PART III

1. Is there anything in the patient's personal medical history which would have increased the risk of coma or epilepsy? Yes () No ()

If yes, please provide details including date of diagnosis, name and address of attending doctor.

2. Is the patient suffering or has suffered from any other significant illness? Yes () No ()

If yes, please state illness, date of first diagnosis and name and practicing address of attending doctor.

Signature of the Medical Specialist who filled up **Section 2**

Practice Stamp of the Medical Specialist

Name (printed) of the Medical Specialist

Date

SECTION 3

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.