

**CRISIS COVER CLAIM FORM
(MUSCULAR DYSTROPHY)**

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 NRIC No

Address

Date of Birth Contact No Occupation

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) |
|---|----------------------|
| ▪ Crisis Cover/ Crisis Cover Provider/ PruMultiple Crisis Cover / Crisis Waiver / Critical Illness Waiver | <input type="text"/> |
| ▪ PruEarly Staged Crisis Cover | <input type="text"/> |
| ▪ 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
(MUSCULAR DYSTROPHY)**

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

1. Please provide details of investigations conducted (e.g. muscle biopsy, electromyography, blood tests, genetic testing etc).

Please provide copies of muscle biopsy, electromyography, laboratory tests and results.

2. Please provide details, including dates, of the extent of the neurological deficits.

3. Please give details of current treatment.

4. Given the Activities of Daily Activities (ADL) definition below, please confirm which of the following the patient is able/ unable to undertake:

a) Washing

Is the patient able, without assistance, to do the following:

- The ability to wash in the bath or shower (including getting into and out of the bath or shower) or Yes () No ()
- Wash satisfactorily by other means? Yes () No ()

If the answers are NO, will the inability to perform (whether aided or unaided) last for a continuous period of at least 6 months? Yes () No ()

Please also state why and how much assistance is required, and on what date the patient became unable to perform these tasks.

b) Dressing

Is the patient able, without assistance, to put on, take off, secure and unfasten all garments and as appropriate, any braces, artificial limbs or other surgical appliances? Yes () No ()

If the answers are NO, will the inability to perform (whether aided or unaided) last for a continuous period of at least 6 months? Yes () No ()

Please also state why and how much assistance is required, and on what date the patient became unable to perform these tasks.

c) Transferring

Is the patient able, without assistance, to move from a bed to an upright chair or wheelchair and vice versa? Yes () No ()

If the answers are NO, will the inability to perform (whether aided or unaided) last for a continuous period of at least 6 months? Yes () No ()

Please also state why and how much assistance is required, and on what date the patient became unable to perform these tasks.

d) Mobility

Is the patient able, without assistance, to move indoors from room to room on level surfaces? Yes () No ()

If the answers are NO, will the inability to perform (whether aided or unaided) last for a continuous period of at least 6 months? Yes () No ()

Please also state why and how much assistance is required, and on what date the patient became unable to perform these tasks.

e) Toileting

Is the patient able, without assistance, to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene?

Yes () No ()

If the answers are NO, will the inability to perform (whether aided or unaided) last for a continuous period of at least 6 months?

Yes () No ()

Please also state why and how much assistance is required, and on what date the patient became unable to perform these tasks.

f) Feeding

Is the patient able to feed himself/ herself once food has been prepared and made available without assistance?

Yes () No ()

If the answers are NO, will the inability to perform (whether aided or unaided) last for a continuous period of at least 6 months?

Yes () No ()

Please also state why and how much assistance is required, and on what date the patient became unable to perform these tasks.

PART III

1. Does the patient have or ever had any other significant health condition? If yes, please provide details of the condition, including diagnosis, date of diagnosis and treatment received.

2. Are you aware of any blood relative suffering from a similar or related illness? If yes, please state the relationship, nature of illness and date the illness was first diagnosed, if known.

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.