PRUDENTIAL

Reg. No 199002477Z

CRISIS COVER KIDS CLAIM FORM

(SEVERE ASTHMA)

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 is furnished at the expense of the claimant.

Mandatory Required documents for claim submission:

1. Crisis Cover Kids 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 Kids	

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 ______

1. TYPE OF CLAIM

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

Crisis Cover Kid Illnesses

- Severe Asthma ☐
- Major Head Trauma ☐
- Brain Surgery ☐
- Loss of Limbs ☐
- Leukaemia ☐
- Severe Epilepsy ☐
- Insulin-Dependent Diabetes Mellitus ☐
- Rheumatic Fever with Valvular Impairment ☐
- Kawasaki Disease with Heart Complications ☐
- Severe Juvenile Rheumatoid Arthritis ☐
- Glomerulonephritis with Nephrotic Syndrome ☐
- Bone Marrow Transplant ☐

2. NATURE OF CLAIM

2.1 Describe fully the extent and nature of illness/injury. If the 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 On which date did you / the child first consult a medical practitioner in connection with the illness/injury?

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

2.5 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
Name of Doctor	**Name and Address of Clinic/ Hospital**	**Dates of Consultation**	**Reason for Visit**

2.6 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 Have any of your/ the child's blood relatives suffered from a similar or related illness? If 'yes', please give full details:

Relationship of Kin

Nature of Illness

Date of Diagnosis

3.2 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

3.3 Do you/ the child 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
(SEVERE ASTHMA)

The abovenamed is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with **Severe Asthma.** To enable us to assess the claim, we would be grateful for your assistance in the completion of this form.

GENERAL

1. Are you the patient's usual medical attendant? Yes ☐ No ☐

   If 'yes' over what period do your records extend? ______

2. When were you first consulted for this condition?

3. What were the symptoms presented when you first attended to the patient? And how long had the symptoms been present when you first saw the patient?

4. Has the child missed anytime off work or school due to this condition and for which medical certificates were provided?

MEDICAL DETAILS

5. Please provide full and exact details of the diagnosis of **Severe Asthma.**

6. Date of diagnosis.

7. Please provide details on how diagnosis was first made.

8. On which date did the patient first become aware of the diagnosis?

9. When did the **parent of the patient** first become aware of the diagnosis?

10a. Is the condition acute or chronic?

10b. In clinical terms, is the condition mild, moderate or severe? Please provide details regarding the severity of the condition.

10c. Date admitted to hospital:

10d. Date discharged from hospital:

10e. Please provide details with dates whether the patient was placed on assisted ventilation with a mechanical ventilator machine upon admission to the hospital.

10f. How many hours was the patient on mechanical ventilation? Was the period continuous?

11. Is the patient on continuous daily usage of oral corticosteroids to control asthma? If so, how long has the patient been on oral corticosteroids?

12. Does the patient exhibit Harrison's sulcus chest deformity?

13. Does the patient have significant growth impairment:

a. Due to asthma -- Yes ☐ No ☐

b. Evidenced by patient's height below the third --------- percentile for his/her age and sex Yes ☐ No ☐

c. Where patient's height has previously been ------------ recorded at or above the fifth percentile at a routine development examination Yes ☐ No ☐
(Please state patient's age at this examination: _________________________)

14. Was the patient admitted to hospital **at least 3 times per year for the past 2 years** to control acute attacks of asthma?

Yes ☐ No ☐

If yes, please provide details of 3 hospitalisation for each of the past 2 years:

Name & Address of Hospital	Date of Admission	Date of Discharge

15a. Is there significant and persistent limitation of the peak expiratory flow rate?

Yes ☐ No ☐

If yes, please provide details of all recordings of the patient's peak expiratory flow rate below. The recordings must be made on at least 4 occasions at intervals of no less than 1 month in a period of at least 12 months.

Date of recording	Maximum peak expiratory flow rate	Is rate less than 80% or the rate predicted for a child of the same age, sex and build?

15b. Was the patient complying with optimal prescribed asthma medication throughout the period of these recordings?

15c. Please state the medication used.

16. Please provide details of all investigations performed and treatment prescribed. Please attach a copy of the laboratory/Histology investigation results.

17. Has the patient **previously** suffered from the condition specified above or any possible related illness?

Yes ☐ No ☐

If 'yes', please give dates of consultations and the resulting diagnosis.

18. Was HIV and antibody test done? Yes ☐ No ☐

If yes, please provide dates and results of all HIV and antibody tests done. Please also attach copies of all relevant laboratory reports.

19. Does the patient have any personal history of any other major medical or psychiatric condition?

Yes ☐ No ☐

If yes, please give details including nature of condition, date of onset, treatment received and current status of the condition.

20. Does the patient have any family history of any major medical condition?
If yes, please provide details including relationship to patient, nature of condition and age of onset.

21. Please provide the names, addresses and qualifications of all doctors, hospitals or clinics the patient has been referred or attended to for this condition

We would be grateful for copies of any relevant hospital reports that are available.

22. If there is any further information which, in your opinion, will assist the Company in assessing the claim, please give details.

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.

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