

# CRISIS COVER KIDS CLAIM FORM

## (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 examiner's 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	<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**

- Crisis Cover Kids

**Policy Number(s)****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     | <input type="checkbox"/> | • Insulin-Dependent Diabetes Mellitus        | <input type="checkbox"/> |
| • Major Head Trauma | <input type="checkbox"/> | • Rheumatic Fever with Valvular Impairment   | <input type="checkbox"/> |
| • Brain Surgery     | <input type="checkbox"/> | • Kawasaki Disease with Heart Complications  | <input type="checkbox"/> |
| • Loss of Limbs     | <input type="checkbox"/> | • Severe Juvenile Rheumatoid Arthritis       | <input type="checkbox"/> |
| • Leukaemia         | <input type="checkbox"/> | • Glomerulonephritis with Nephrotic Syndrome | <input type="checkbox"/> |
| • Severe Epilepsy   | <input type="checkbox"/> | • Bone Marrow Transplant                     | <input type="checkbox"/> |

**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?  
If 'yes', please give full details: -

Yes  No

What is your daily  
consumption?

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 EPILEPSY)

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 Epilepsy**. To enable us to assess the claim, we would be grateful for your assistance in the completion of this form.

Name of Specialist

MCR No.

Field of Specialty

Name of Medical Institution

### 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 Epilepsy**.

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?

10. Has the patient experienced **recurrent unprovoked tonic-clonic or grand mal seizures**?

11. Is the seizure caused by a disorder of the brain?                      Yes                       No

Please provide details.

12. Has the patient undergone neurosurgery for treatment of epileptic seizures?

Yes                       No

If yes, please provide details with dates of surgery.

13. Is the patient taking prescribed anti-epileptic (anti-convulsant) medication?

Yes  No

If yes, how long has the patient been on such medication? Please give the name of medication and the date patient was first given such medication.

14. Please provide details of all investigations performed (including EEG, MRI, PET etc.) and treatment prescribed. Please attach a copy of the laboratory / investigation results.

15. 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.

16. 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.

17. 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.

18. 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.

19. 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.**

20. 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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