

Accidental Benefit Claim / Hospitalisation Claim Form

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

1. **The Company does not admit liability by the mere issue of this form.**
2. **Please complete and return this form together with the Medical Report and the original Medical Certificate, Original bills and receipts to the Company.**

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

POLICY DETAILS

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

Benefit Type

- Comprehensive Personal Accident/ PruAccident Cover/
Weekly Hospital Benefit/ Hospital Cash Benefit/
PruMedical Cash Benefit

Policy Number(s)

 Accidental Dismemberment/Permanent Disablement* Medical Reimbursement Weekly Hospital/Hospital Cash/Hospital Income* Weekly Income/Temporary Disablement* Daily Hospital Income/ Daily Intensive Care Unit* Others: Please specify: _____

* Please delete as appropriate

DECLARATION

I hereby declare that all information given by me in this form is, 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

Details of Illness

1. Nature of illness
- (a) Date symptoms first started:
- (b) Date first treated:
2. Is the illness still being treated? Yes No
- (a) If YES, please state nature of ongoing treatment and approximate date of completion.
- (b) If NO, please state date of last treatment or appointment.
3. Has the illness been treated previously? Yes No
- (a) If YES, please state date of previous treatment.
- (b) Please state name and address of attending doctor for previous treatment.

Details of Accident

4. Date and Time of Accident:
5. Describe in detail how the accident happened, stating the location and injuries sustained.
6. Was there a police report? If yes, please provide a copy. Yes No

Other Information

7. Date of hospitalisation: From To
8. Date of medical leave: From To
9. Date of surgical procedure:
10. Please provide details on any surgical procedure performed.
11. Are you claiming Medical Expenses from other sources? Yes No

If 'Yes', please provide details of claim:

Name of Company	Nature of Claim	Amount Claimed	Policy Number (if applicable)

12. Details of doctor(s) or hospital(s) admitted for this disability.
- | Name | Address(s) | Consultation/Admission Date |
|------|------------|-----------------------------|
| | | |
| | | |

13. Details of doctor(s) you consulted for any disorder on or before this hospitalisation.

Name	Address(s)	Consultation Date

MEDICAL REPORT FOR ACCIDENTAL / HOSPITALIZATION / SURGICAL PROCEDURE CLAIM

SECTION 2

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

Part 1 – Medical Information

1. Name of Patient
2. NRIC Number
3. Is this condition due to an illness or an accident? Illness Accident
4. Date of diagnosis of illness / Date of accident
5. Diagnosis of the illness / injury
6. Cause of illness / injury
7. Is this a job-related injury? Yes No
If yes, please give details.
8. Date you were first consulted for the injury / illness.
9. Main complaints at this first consultation.
If treatment is due to **injury**, please provide details on nature and extent of injuries sustained
10. Has the patient been treated previously for this condition? Yes No
 - a. If YES, please state the date of first consultation.
 - b. Please indicate approximate date from which the patient first noticed symptoms of condition.
 - c. In your view, if the condition existed before symptoms became apparent to the patient, please indicate when this condition began to develop.
 - d. Was patient informed of the diagnosis and understood it?

11. Details of any permanent disability the patient sustained as a result of the illness / injury

12. Is the above condition associated with the following:

- | | | |
|--|------------------------------|-----------------------------|
| a. Any condition resulting from pregnancy, childbirth or miscarriage or abortion | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b. Any form of dental care or surgery | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c. Any treatment for obesity, weight management program | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d. Eye test, refractive errors of eyes, photo refractive keratectomy, cosmetic or plastic surgery and the provision of appliances, including spectacles lenses, hearing aids, artificial organs or joints, wheelchair & prosthesis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| e. Any elective surgery, cosmetic or plastic surgery not necessitated by injury or illness | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| f. Routine health check-up, custodial or rest care | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| g. Mental illness and psychiatric disorders | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| h. Infertility, contraception, sterilisation, circumcision | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| i. Human Immunodeficiency Virus infection, AIDS or any sexually transmitted diseases | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| j. Birth defect or congenital anomalies | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| k. Alcohol, drug abuse or the use of unprescribed drugs where such drugs are required by law to be prescribed by a registered doctor | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| l. Participation as a professional in competitive sports | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| m. Self inflicted injury e.g. voluntary causing hurt, attempt suicide, participating in hazardous activity (e.g. scuba diving, bungee-jumping, mountaineering). | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

13. If your answer to any of the conditions listed under Question 12 is "Yes", please provide details.

Part 2 – Hospitalisation Room & Board

2.1. Name of hospital patient was admitted to:

2.2. Please indicate how the patient was admitted:

Emergency admission Doctor referral

Please provide Doctor's name and address

2.3. Date and time of admission:

2.4. Date and time of discharge:

2.5. Date of medical leave

Part 3 – Surgical Procedure

3.1. Were surgical procedures performed on the patient?

Yes

No

If your answer is " Yes ", please put a tick in the box alongside the categories of procedures listed below:

- a. Skin
- b. Musculoskeletal System
- c. Respiratory System
- d. Cardiovascular System
- e. Haemic & Lymphatic System
- f. Digestive System
- g. Urinary System

- h. Male Genital System
- i. Female Reproductive System
- j. Endocrine System
- k. Nervous System
- l. Eye
- m. Ear / Nose / Throat
- n. Endoscopies

3.2. Please describe in detail the surgical operation(s) performed on the patient.

3.3. Please state the objective(s) of the operation(s)

3.4. If 2 or more of the surgical procedures were performed, were they performed under the same anaesthesia?

Yes

No

If your answer is "No", please give details.

3.5. Date of surgical operation(s)

3.6. Is patient still under your care for this condition?

Yes

No

If 'No', please give the date of the last consultation.

3.7. If no surgery was performed, was surgery advised?

Yes

No

If 'Yes', please give reasons why patient did not proceed with the surgery.

Part 4 – Reference

4.1. Name and Address of doctor(s) previously consulted by patient for this condition

I hereby certify that the answers given are complete, full and true to the best of my knowledge.

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

Please enclose all relevant clinical, radiological, histological, operation and laboratory reports by attaching them to this page.