

PruHospital Income Claim Form (To be completed by Claimant)

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

Personal Particulars

| Name of Claimant | NRIC Number | Occupation | Policy Number |
|------------------|-------------|------------|---------------|
| | | | |

| Address | Age | Telephone |
|---------|-----|-----------|
| | | |

Details of Claim

Benefit Plan Type

Plan 1

Plan 2

Plan 3

Types of Claim

Daily Hospital Income

Discharge Transportation Grant

Daily Hospital Overseas Income

Recuperation Grant

Daily Intensive Care Unit Benefit

Temporary Disablement Benefit

Compassionate Boarding Fee

Death

Hospital Expenses (Illness) Reimbursement

24-Hour Worldwide Accidental Emergency Assistance Service

Hospital Expenses (Accident) Reimbursement

Details of Illness / Injury

1. What is the cause of illness / injury

| | | |
|----------------------------------|-----------------------------|----------------------|
| <input type="checkbox"/> Illness | Date symptoms first started | <input type="text"/> |
|----------------------------------|-----------------------------|----------------------|

| | | |
|-----------------------------------|---------------------------|----------------------|
| <input type="checkbox"/> Accident | Date and Time of Accident | <input type="text"/> |
|-----------------------------------|---------------------------|----------------------|

2. Was there a police report Yes No
(If Yes, please provide a copy.)

3. Describe in detail the nature of the illness / injury. If the condition is caused by an accident, please give details on the accident.

Please go to the benefits that you are claiming for and fill in accordingly

1. Daily Hospital Income Benefit

Date of hospitalization: From _____ to _____

Have you suffered this or a similar condition or a recurrence of a previous illness or injury

Yes No If Yes, please specify _____

Date of first consultation of the injury/illness _____

Date in which you first noticed symptoms of condition _____

2. Daily Hospital Overseas Income (Applicable to hospital in the USA, Canada, Switzerland, Japan or member of the European Union)

Country visited _____ Duration of visit _____

Purpose _____

State the country of hospital _____

Date of hospitalization: From _____ to _____

3. Daily Intensive Care Unit Benefit

Number of ICU stays: _____

4. Compassionate Boarding Fee

Names of Boarders _____ relationship _____

Date of boarding: From _____ to _____

5. Hospital Expenses (Illness) Reimbursement

Medical Expenses _____

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) |
|-----------------|-----------------|----------------|-------------------------------|
| | | | |
| | | | |
| | | | |

6. Hospital Expenses (Accident) Reimbursement

Medical Expenses _____

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) |
|-----------------|-----------------|----------------|-------------------------------|
| | | | |
| | | | |
| | | | |

7. Discharge Transportation Grant

8. Recuperation Grant

9. Temporary Disablement Benefit

Date of medical certificates : From _____ to _____

10. Death

Date of Death : _____

Cause of Death : _____

Name of Claimants : _____

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 me concerning anything which affects my physical or mental health; and
- b) seek information from any insurance office to which a proposal has been made for insurance on my life.

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.

Signature of Claimant:

Date: