

PRUMUM2BE CLAIM FORM

This form must 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.

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.

Required documents for claim submission:

1. PruMum2Be Lady Claim Form (all sections must be completed)
2. Clinical Abstract Application Form (3 copies)
3. Medical Specialist Report (please select the appropriate form depending on the medical condition)
4. Diagnostic laboratory and objective test reports supporting the diagnosis

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

- PruMum2Be

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 the appropriate box.

PruMum2Be Benefit

a) Death Benefit *(please complete sections 1, 4 and 5)*

- Death of Life Assured

b) Pregnancy Complications *(please complete sections 1, 2, 3 and 5)*

- Disseminated Intravascular Coagulation
- Pre-Eclampsia or Eclampsia
- Aminotic Fluid Embolism
- Postpartum Haemorrhage
- Death of Foetus *(Refund of Premium on PruFirstGift -PPA)*
- Fatty Liver of Pregnancy
- Abruptio Placentae

c) Congenital Illnesses *(please complete sections 1, 2, 3 and 5)*

- Down's Syndrome
- Tetralogy of Fallot
- Atrial Septal Defect
- Absence of Two Limbs
- Infantile Hydrocephalus
- Cerebral Palsy
- Congenital Dislocation of Hips
- Congenital Deafness
- Retinopathy of Prematurity
- Spina Bifida
- Transposition of Great Vessels
- Ventricular Septal Defect
- Anal Atresia
- Cleft Palate/ Cleft Lip
- Club Foot
- Congenital Blindness
- Congenital Diaphragmatic Hernia

d) Hospital Care *(please complete sections 1, 2, 3 and 5)*

- Incubation of newborn child for more than 3 consecutive days immediately following birth
- Hospitalisation due to Hand, Foot and Mouth Disease
- Premature birth requiring neonatal ICU

2. NATURE OF CLAIM

2.1 Describe fully the extent and nature of illness/injury.

2.2 On which date did you first consult a medical practitioner in connection with the illness/injury?

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 Have any of your 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 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?

4. DEATH BENEFIT

Please complete this section only if the claim is filed on Death of Life Assured.

4.1 Describe fully the extent and nature of illness/injury.

4.2 How long was the deceased ill?

4.3 What is the name and practice address of the medical practitioner who attended to the deceased in connection with the illness/injury?

4.4 Did the deceased leave a Will? Yes No

If yes, please state the name of the Executor. Please also enclose the last Will and NRIC of the Executor.

4.5 What is the deceased's marital status?

4.6 Please state the surviving family members of the deceased and the age of children.

4.7 Did the deceased give birth to her child insured under this policy? Yes No

- i) If yes, please provide a copy of the birth certificate of the child.
- ii) If no, please provide documentary proof of termination of pregnancy

5. 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:

- d) 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; and
- b) seek information from any insurance office to which a proposal has been made for insurance on the life assured.

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.

Policyowner/ Claimant's
Signature

Date

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