PRUDENTIAL

PRUSHIELD CLAIM FORM (Manual Submission)

The Company does not admit liability by the mere submission of this form and the required documents.

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.

PruShield Policy No. ____________

Required documents for claim submission:

1. Prushield Claim Form (Manual Submission) - all 4 sections must be completed. Section 3 must be completed by specialist doctor treating the life assured.
2. Clinical Abstract Application Form (3 copies)
3. Original copy of final hospital bills, payment receipts and tax invoice
4. Medical Report, Laboratory Reports

If you are a foreigner who is not a Singapore Permanent Resident, please also submit the following documents:

5. Certified True Copy of passport
6. Certified True Copy of employment pass or dependent pass and relevant documents showing the right to stay in Singapore

If the claim is for final expense (death) claim, please also submit the following documents:

7. A copy of the death certificate
8. Proof of relationship of claimant to deceased life assured (e.g. marriage certificate, birth certificate)
9. Death Claimant Statement

SECTION 1

This section is to be completed by the Life Assured. If the Life Assured is below 18 years old, parent or legal guardian may assist with the completion.

LIFE ASSURED'S PARTICULARS

Full Name ____________ NRIC No ____________

Address ____________

Date of Birth ____________ Contact No ____________ Occupation ____________

TYPE OF CLAIM

☐ PruShield In-Patient ☐ PruShield Outpatient ☐ PruShield Day Surgery ☐ Final Expense

☐ PruShield As Charged Pre/ Post Hospitalisation
(You claim for Pre/Post hospitalisation only if you have received our letter informing you that PruShield claim for InPatient hospitalisation or Day Surgery has been approved.)

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

SECTION 2
This section is to be completed by the Life Assured. If the Life Assured is below 18 years old, parent or legal guardian may assist with the completion.

1 Hospital Admission Detail

1.1 Date of Hospitalisation From ______ To ______

1.2 Name of Hospital Admitted ______

2 Medical Information

2.1 Why was the life assured hospitalised?

2.2 Who had referred the life assured to the hospital?

Name of Doctor	Clinic Name / Branch	Dates of Consultations

2.3 Please answer Questions 4.3(a) to 4.3(d) if the hospitalisation is due to an illness.

a. What was the diagnosis?

b. Since when did the life assured first noticed the symptoms of this illness?

c. Describe these symptoms.

d. The name and address of the doctor whom the life assured have consulted for these symptoms?

Name of Doctor	Clinic Name / Branch	Dates of Consultations

2.4 Please answer Questions 4.4(a) to 4.4(g) if the hospitalization is due to an injury caused by an accident.

a. Date of accident

b. Place of accident

c. How did it occur?

d. Was there any witness(es) when the accident occurred? Yes ☐ No ☐

If yes, please give us the following information.

Name of Witness(es)	Contact Number	Relationship to you

Was a police report filed? Yes ☐ No ☐
If yes, please give us a copy.

e. Describe your injury.

f. Have the life assured previously received treatment for this injury?
If yes, please provide us the following information.

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

3 Details of your regular physician or any other physician(s) consulted for any other disorders in the past three years

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

4 Is the life assured insured for similar benefits or has submitted a claim for the same illness or injury with any other insurance company, his/ her employer or any other source?

Yes ☐ No ☐

If yes, please state details below and provide a copy of their settlement letter :

Name of Company	Nature of Claim	Amount Claimed	Policy Number

I hereby declare that all information given by me in this form is, to the best of my knowledge and belief, true and complete.

Name & Signature of Life Assured or Policyowner if Life Assured is below 18 years old

Date

SECTION 3
This section is to be completed by the life assured's attending specialist doctor.

SPECIALIST DOCTOR REPORT

Part 1 – Specialist Doctor's Particular

1. Name of Specialist Doctor

2. Medical Council Registration Number

3. Practicing Medical Institution

Part 2 – Medical Information provided by specialist doctor

4. Is this condition due to an illness or an accident?

5. Date of diagnosis of illness / Date of accident

6. Diagnosis of the illness / injury
   Please state ICD10 AM code

7. Cause of illness / injury

8. Is this a job-related injury? Yes ☐ No ☐

   If yes, please give details.

9. Date you were first consulted for the injury / illness.

10. Main complaints at this first consultation. If treatment is due to injury, please provide details on nature and extent of injuries sustained

11. Has the patient been treated previously for this condition? Yes ☐ No ☐

    a. If yes, please state when.

    b. Please indicate approximate date from which the patient first noticed symptoms of medical condition or injury.

    c. Date when the patient or his next of kin is aware or informed of the condition before symptoms became apparent

    d. When did this condition begin to develop?

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

12. Is the illness or injury and the treatment prescribed associated with the following:

		Yes	No
a.	Congenital anomalies, hereditary conditions and disorders	☐	☐
b.	Mental illness and personality disorders	☐	☐
c.	Pregnancy, or any form of hospitalization or treatment relating to pregnancy, childbirth, abortion or miscarriage	☐	☐
d.	Infertility, sub-fertility, assisted conception or any contraceptive treatment	☐	☐
e.	Treatment of sexually transmitted diseases	☐	☐
f.	Acquired Immunodeficiency Syndrome (AIDS), AIDS related complex or infection by Human Immunodeficiency Virus (HIV)	☐	☐
g.	Treatment of self-inflicted injuries, or injuries resulting from attempted suicide	☐	☐
h.	Treatment for drug addiction or alcoholism	☐	☐
i.	Cosmetic surgery or plastic surgery	☐	☐
j.	Dental treatment	☐	☐
k.	Sex change operations	☐	☐
l.	Is this examination/hospital admission for diagnosis purpose or general health wellness check up or X Ray	☐	☐

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

Part 3 – Hospitalisation Room & Board

14. Name of hospital patient was admitted to

15. Date and time of admission

16. Date and time of discharge

17.. Please indicate how the patient was admitted

- [ ] A&E admission
- [ ] Referral by a specialist doctor (please provide the name and practice address of the specialist)

Part 4 – Surgical Procedure

18. 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

19. Please describe in detail the surgical operation(s) performed on the patient.
(Please also state the TOSP Codes)

20. Please state the purpose of the operation

21. Date of surgical operation(s)

22. Is patient still under your care for this condition? Yes ☐ No ☐

Please give date of last consultation

23. What was the status of the patient's condition at the last consultation?

24. What was the treatment plan at the last consultation?.

25. State date of next follow-up appointment

26. State the aim of the coming appointment

27. If patient is not under your care, please provide the name of the doctor and the practice institution you have referred him/her to:

Part 4 – Reference

28. Name and Practice Institution of doctor(s) previously consulted by patient for this condition

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I hereby declare that the above answers are true to the best of my knowledge and belief and that I agree to a copy of this report to be made available to the patient or the relevant authorities upon their request.

Signature of specialist doctor

Practice Stamp of specialist doctor

Name of specialist doctor

Date of completion of report

SECTION 4
Attachment of Laboratory Reports by the medical treatment centre

Please attach all relevant clinical, radiological, histological, operation and laboratory reports to this page.