

PRUSMART LADY 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. PruSmart 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

- PruSmart Lady

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

PruSmart Lady Benefit

a) Female Illnesses

- | | | | |
|---|--------------------------|---|--------------------------|
| • Systemic Lupus Erythematosus (SLE) with Lupus Nephritis | <input type="checkbox"/> | • Rheumatoid Arthritis | <input type="checkbox"/> |
| • Malignant cancer/ Carcinoma in-situ of breast | <input type="checkbox"/> | • Malignant cancer/ Carcinoma in-situ of cervix | <input type="checkbox"/> |
| • Malignant cancer of uterus | <input type="checkbox"/> | • Malignant cancer of fallopian tube | <input type="checkbox"/> |
| • Malignant cancer of ovary | <input type="checkbox"/> | • Malignant cancer of vagina/ vulva | <input type="checkbox"/> |
| • Chronic Auto-immune Hepatitis | <input type="checkbox"/> | • Osteoporosis requiring surgery or repair | <input type="checkbox"/> |
| • Urinary Incontinence requiring surgical repair | <input type="checkbox"/> | • Uterine Prolapse/ Pelvic relaxation requiring surgical repair | <input type="checkbox"/> |

b) Medical Procedure

- | | | | |
|--|--------------------------|---|--------------------------|
| • Unilateral Breast Lumpectomy due to malignant condition or carcinoma in-situ | <input type="checkbox"/> | • Bilateral Breast Lumpectomy due to malignant condition or carcinoma in-situ | <input type="checkbox"/> |
| • Hysterectomy due to malignant condition | <input type="checkbox"/> | • Mastectomy due to malignant condition | <input type="checkbox"/> |
| • Complicated repair of vaginal fistula | <input type="checkbox"/> | • Radical vulvectomy required due to malignant condition | <input type="checkbox"/> |
| • Wertheim's operation required due to malignant condition | <input type="checkbox"/> | • Total pelvic exenteration required due to malignant condition | <input type="checkbox"/> |

c) Reconstructive Surgery or Skin Grafting

- | | | | |
|--|--------------------------|---|--------------------------|
| • Breast reconstructive surgery following mastectomy | <input type="checkbox"/> | • Facial reconstructive surgery due to accident | <input type="checkbox"/> |
| • Skin grafting due to major burns | <input type="checkbox"/> | • Skin grafting due to skin cancer | <input type="checkbox"/> |

Maternity Risk Cover Benefit

a) Pregnancy Complication

- | | | | |
|---|--------------------------|--|--------------------------|
| • Disseminated Intravascular Coagulation | <input type="checkbox"/> | • Ectopic Pregnancy | <input type="checkbox"/> |
| • Death of foetus of life assured after 195 days of pregnancy | <input type="checkbox"/> | • Death of child of life assured within 28 days of birth | <input type="checkbox"/> |
| • Death of life assured during delivery | <input type="checkbox"/> | • Hydatiform Mole | <input type="checkbox"/> |

- Pre-Eclampsia or Eclampsia
- Aminotic Fluid Embolism
- Fatty Liver of Pregnancy
- Abruptio Placentae

b) Congenital Illnesses

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

c) Hospital Care

- Incubation of newborn child for more than 3 consecutive days immediately following birth
- Premature birth requiring neonatal ICU

2. NATURE OF CLAIM

2.1 Describe fully the extent and nature of illness/injury. If your 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 Have you previously suffered from or received treatment for a similar or related illness/injury? If 'yes', please give details.

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

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

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 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

3.2 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. 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 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.

Life Assured's Signature Date