PRUDENTIAL

Reg. No 199002477Z

PRUMUM2BE CLAIM FORM

(DISSEMINATED INTRAVASCULAR COAGULATION)

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

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.

Mandatory Required documents for claim submission:

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

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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 ______

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	Policy Number(s)
▪ PruMum2Be	

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

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

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

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

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

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

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SECTION 2

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

MEDICAL SPECIALIST REPORT

DISSEMINATED INTRAVASCULAR COAGULATION (DIC)

Name of Specialist [ ] MCR No. [ ]

Field of Specialty [ ]

Name of Medical Institution [ ]

PART I

Please only complete this form if the patient is diagnosed with Disseminated Intravascular Coagulation (DIC). Otherwise, please return the form to the patient.

PART II

1. When were you first consulted for the condition?

	DD		MM		YY

2a. What were the presenting symptoms when you first saw the patient?

2b. When did the above symptoms first present?

	DD		MM		YY

If the date is unknown, please state how long the symptoms had been present prior to the date of first consultation.

3a. Please provide full and exact details of the diagnosis.

3b. Date of diagnosis.

3c. Date the patient was informed of the diagnosis.

4. Please provide dates and details of investigation performed for the diagnosis. Kindly attach copies of all relevant objective test reports, which confirmed the diagnosis.

5a. Were you the doctor who **first** diagnosed the patient with this condition? Yes ( ) No ( )

5b. If yes, over what period do your record extend? From ____ to ____

5c. If you are not the first doctor who diagnosed the patient with this condition, please provide:

(i) name and practice address of the doctor who first made the diagnosis or had treated the patient for this condition.

(ii) date the diagnosis was made by the previous doctor.

(iii) when was the referral made for the patient to see you?

PART III

1. Did DIC occur as a result of pregnancy? Yes ( ) No ( )

2. Please state if the following were present:

(a) Entrance of uterine material with tissue factor activity into the maternal circulation Yes ( ) No ( )

(b) Major hemorrhage? Yes ( ) No ( )

(c) End organ damage as a result of DIC? Yes ( ) No ( )

(d) Significant thrombocytopenia, pro-coagulant activation, fibrinolytic activation and inhibitor consumption Yes ( ) No ( )

(e) Treatment with frozen plasma and platelet concentrates Yes ( ) No ( )

PART IV

1. Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? Yes ( ) No ( )

   If yes, please provide the date of HIV/ AIDS diagnosis.

	DD		MM		YY

2. Is the diagnosis related to the consumption of any intoxicating liquor, drugs or poison, suicide or attempted suicide or intentional self-injury? Yes ( ) No ( )

3. Is the diagnosis related to the use of unprescribed drugs where such drugs are required by law to be prescribed by a registered medical practitioner? Yes ( ) No ( )

4. Was this pregnancy conceived through in-vitro fertilisation? Yes ( ) No ( )

5. Was the patient carrying 3 or more babies in this pregnancy? Yes ( ) No ( )

6. Did DIC occur within the first 7 months of pregnancy? Yes ( ) No ( )

(Note to claims assessor: Q6 is solely for the consideration of PSL)

PART V

1. Was the patient previously diagnosed to be suffering from DIC? Yes ( ) No ( )

   If yes, please provide the following information:

   a) Details of any impairment

   b) Date of diagnosis

	DD		MM		YY

   c) Name and practice address of the doctor who had diagnosed/ treated the patient.

2. Please provide details of the patient's personal medical history and any further information about the patient, which may be of assistance to us in assessing this claim.

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 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

To enable us to proceed with the claim, it is mandatory to enclose all relevant clinical, radiological, histological, operation and laboratory reports by attaching them to this page.