

## TERMINAL ILLNESS CLAIM FORM

### 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.

#### Required documents for claim submission:

1. Terminal Illness 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

**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	<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

- Terminal Illness

#### 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

Terminal Illness Benefit

**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 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 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?  
If 'yes', please give full details: -

Yes  No

What is your daily consumption?  sticks/ per day

For how long have you been smoking?

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## MEDICAL SPECIALIST REPORT

### SECTION 2

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

#### PART I

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 II

1. Has active therapy now been rejected in favour of relief of symptoms?

2. Please give details of current treatment.

3. Can you confirm that the advent of death is highly probable within twelve months?

4. Please give the names and addresses of all consultants, specialists or hospitals to which the patient has been referred or attended for this condition.

## PART III

1. Is there anything in the patient's habits or personal medical history which would have increased the risk of the medical condition resulting in terminal illness? If 'yes', please give details.

2. Is there anything in the patient's family history which would have increased the risk of the terminal condition? If 'yes', please give details.

3. Does the patient have or ever had any other significant health condition? If yes, please provide details of the condition, including diagnosis, date of diagnosis and treatment received.

4. Has the patient ever been tested positive for HIV/AIDS or is he/she awaiting the result of such a test?  
Yes ( ) No ( )

Do you have any reason to suspect that the patient is HIV positive?

Signature

Practice Stamp

Name (printed)

Date

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**SECTION 3**  
**Attachment of Laboratory Reports**

Please enclose all relevant clinical, radiological, histological, operation and laboratory reports by attaching them to this page.