

Disability Claim Form (Adult)

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. Disability Claim Form (all sections must be completed)
2. Clinical Abstract Application Form (3 copies)
3. Attending Physician Statement
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 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 you would like to claim.

Benefit Type

- Total & Permanent Disability
- Early Stage Disability

Policy Number(s)

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

Details of Occupation

	Before disability	After disability
Occupation		
Name of Employer		
Average monthly income		
List exact duties performed at work [see note (i)]		

Note: i) If you are not working, please provide a list of daily activities before and after the disability
 ii) The Company reserves the right to request for documentary evidence

Details of Disability

Is the disability suffered due to:

<input type="checkbox"/> Illness	<input type="checkbox"/> Accident
(date symptoms started)	(date/time of accident)

Describe in detail all symptoms and/or nature of injuries/disability suffered

Have you had any tests or investigations to confirm the diagnosis? Please include dates.

What treatment have you received, and are currently receiving in connection with your illness? Please include dates.

Date you last worked

Are you currently confined to:

<input type="checkbox"/> bed	<input type="checkbox"/> house
<input type="checkbox"/> neither	

Date you returned to work

OR Date you expect to return to work

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If the claim is on Early Stage Disability, please tick against the QLCs that you are claiming for:

√	Quality of Life Conditions (QLCs)	Date Disability Started
	Walking – Inability to walk more than 200m on a level surface continuously with or without aids and adaptations, within 5 minutes, because of breathlessness or severe pain	
	Fine Hand Control – Inability to remove 5 paracetamol pills from a blister pack within 60 seconds, using your hand(s) with or without aids and adaptations	
	Sitting and Rising from a chair – Inability to sit and rise to a standing position from a wheelchair or chair (both with arms) of 40cm to 45cm in height without the help of another person	
	Lifting and carrying – Inability to lift (from a bench with a height of 1 metre) and carry a 2kg weight for 10m and then placing it back down at bench height, with or without aids and adaptations	
	Communicating – As a result of an illness or injury, the inability to hear sounds of below 60 decibels in all frequencies of hearing or the inability to speak with sufficient clarity.	
	Eye Sight – When tested with visual aids, vision is measured at 6/60 or worse in one of the eyes using a Snellen eye chart.	

Details of physician(s) consulted or hospital(s) admitted for this disability

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

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

Are you claiming from any other insurance company or other sources in respect of this disability?
 If yes, please provide following information.

Name of Insurer	Type of Plan	Date of Issue	Benefit Amount

MEDICAL SPECIALIST REPORT

SECTION 2
 This section is to be completed by the life assured's attending medical specialist.

Name of Specialist MCR No.

Field of Specialty

Name of Medical Institution

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, their frequency and severity.

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

3b. Date of diagnosis.

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

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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.

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

5b. If yes, over what period do your records extend? From

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 to

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5c. When was the patient last seen for this condition?

	DD		MM		YY
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5d. 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.

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

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

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PART II

1. Please describe the nature and severity of the patient's disability in respect of this illness or injury.

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2. To what extent does his disability prevent him from performing all the normal duties of his usual occupation?

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3. If he cannot return to his usual occupation, can he engage in any other types of occupation?

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4. When do you think the patient will be able to return to work, part time or full time?

5. Are there any social, domestic or employment issues that are, or have been, impacting the patient's ability to work? If yes, please provide details.

6. Please provide details of any treatment that has been provided to the patient, including any operation and the date(s) performed.

7. If medication has been prescribed, please state dosage and whether any changes have been made since the initial onset of the disability.

8. To your knowledge, has the patient been fully compliant with the treatment suggested?

9. How is the patient's disability responding to the treatment? Please describe progress and extent of recovery.

10. Is the patient's condition improving, static or deteriorating?

PART III

1. Has the patient's functional ability been tested? Yes () No ()

2. Please describe the patient's current level of functional in the following tasks

RATING GUIDE	
Score 1	Able without assistance
Score 2	Able but some help/ supervision is needed
Score 3	Needs someone to help most of the time
Score 4	Not able to perform at all

Activity	Score (refer to Rating Guide)	Date from which help was required	Equipment needed	Help needed from another person
Walking Walk more than 200m on a level surface continuously within 5 minutes, without having to stop because of breathlessness or severe pain				
Fine Hand Control To remove 5 paracetamol pills from a blister pack within 60 seconds using your hand(s)				
Sitting and Rising from a chair To sit and rise to a standing position from a wheelchair or chair (both with arms) of 40cm to 45cm in height				
Lifting and Carrying To lift (from a bench with a height of 1 metre) and carry a 2kg weight for 10m and then placing it back down at bench height				
Communicating To hear sounds of below 60 decibels in all frequencies of hearing or the ability to speak with sufficient clarity. Please attach ENT report.				
Eyesight Vision is measured at 6/60 or worse in one of the eyes using a Snellen eye chart, when tested with visual aids. Please attach Ophthalmologist report.				

3. (a) How would you assess the patient's degree of limitation in performing the following activities?
(Please tick)

	Not Limited	Mildly Limited	Moderately Limited	Severely Limited	Incapable
Seeing / Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing / Sound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reasoning / Mental Faculty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changing Posture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working with both hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting & Carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the lavatory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above the shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk on uneven surface	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inability to move in / out of chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(b) To what extent can the patient use his/her hand?

	Right Hand	Left Hand
Simple Grasping		
Fine Manipulation		
Forearm rotation movement		
Power Grip		
Pushing / Pulling		

(c) What is the patient's power of limbs:

Right Upper Limb Right Lower Limb

Left Upper Limb Left Lower Limb

4. In your opinion, is the patient
 (a) totally and permanently disabled AND
 (b) cannot engage in any occupation, business or activity which pays an income.

If yes, when did such disability commence?

5. (a) Is the patient suffering from total and irrecoverable loss of use of the right eye and the left eye?

Yes () No ()

If yes, please give details

If yes, when did such disability commence?

(b) Is the patient suffering from total and irrecoverable loss of use of any two limbs, excluding hands and feet?

Yes () No ()

If yes, please give details

If yes, when did such disability commence?

(c) Is the patient suffering from total and irrecoverable loss of use of one eye and any one limb, excluding hands and feet?

Yes () No ()

If yes, please give details

If yes, when did such disability commence?

PART IV

1. Please indicate if the patient's condition is as a result of any of the following activities:

• winter sports, ice hockey	Yes ()	No ()
• horse riding, polo playing	Yes ()	No ()
• canoeing, sailing or windsurfing	Yes ()	No ()
• mountaineering, rock climbing, caving, potholing, hunting	Yes ()	No ()
• hang gliding, sky diving, parachuting	Yes ()	No ()
• scuba diving	Yes ()	No ()
• boxing, wrestling, martial arts activities, whether in training or in competition	Yes ()	No ()
• motocross	Yes ()	No ()
• military service	Yes ()	No ()

2. Has the patient previously consulted you or any other doctor for treatment or advice for this or any related condition? Yes () No ()

If yes, please provide full details especially dates, treatment and any time and practicing address of doctor.

3. 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.

4. Please give details of the patient's habits in relation to past and present smoking, including the duration of smoking habits, number of cigarettes smoked per day and source of this information.

5. Please give details of the patient's habits in relation to alcohol assumption, including the amount of alcohol consumption per day and source of this information.

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

Practice Stamp

Name of Specialist

Date

SECTION 3
Attachment of Laboratory Reports

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

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