Reg. No 199002477Z

Disability Claim Form (Juvenile)

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. 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

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	Policy Number(s)
▪ Total & Permanent Disability	
▪ Early Stage Disability	

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

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Details of Disability

Is the disability suffered due to:

☐ Illness

(date symptoms started)

☐ Accident

(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:

☐ bed ☐ house

☐ neither

Date you returned to work

OR Date you expect to return to work

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

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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

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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 [ ]

1. Consultation for present illness/injury
   (a) Are you the patient's usual physician? [ ] Yes [ ] No

   If yes, since what date? [ ]

(b) When did the patient first consult you for this Illness or injury?

(c) If consultation was for illness, please provide the following information:

(i) symptoms presented

(ii) duration of these symptoms

(iii) diagnosis

(iv) was the diagnosis made known to the patient? Yes ☐ No ☐

If yes, when? If no, why?

(d) If consultation was for injury please describe injuries:

2. Patient's condition
(a) Please describe the nature and severity of the patient's disability.

(b) To what extent does his disability prevent him from performing all the normal duties of his usual occupation ?

(c) If he is unable to return to his usual occupation, can he engage in any other type of occupation?

3. Please describe treatment, including any operations performed.

4. Has the patient been referred from a clinic or hospital? Yes ☐ No ☐

If Yes, please state:
(a) Name of physician

(b) Name of clinic/hospital

(c) Date referred

5. Has the patient been admitted to hospital before for the same illness/injury? Yes ☐ No ☐
If yes, please state:
(a) Date admitted

(b) Date discharge

(c) Name of hospital

(d) Admission No.

6. (a) Has the patient suffered or is suffering from any other disease or ailment? Yes ☐ No ☐

If yes, please give details.

(b) Date he first suffered from the disease or ailment

(c) Name and address of physician consulted

7. Has the patient been confined to a home, hospital or other institution requiring constant care and medical attention for at least 4 consecutive months? Yes ☐ No ☐

Please state the period of such confinement.

8. Please provide us with any other additional information that will enable the company to assess this claim.

Date

Signature of Physician

Official Stamp

Name

SECTION 3
Attachment of Laboratory Reports

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