Policy number:	

Accident Claim / Hospitalisation Claim Form

Important notice

To avoid delay in processing your claim, please send us your completed claim form together with the supporting documents within 30 days from the date of the event.

Details of Life Assured

Full Name		NRIC No:										
Address		Postal Code										
Date of Birth								Contact No:				

Payee's Details

Payment will be made via direct transfer to policyholder's bank account. Please indicate the bank details clearly for us to process the payment. A copy of the bank book or bank statement stating account holder name and number is required.

Name of Account Holder	Name of Bank	Bank Account Number

Accident or Illness claim details

1. Details of Injury or illness

Is the disability or condition suffered due to ☐ Accident ☐ Illness?

Details of Accident (Complete this section if you are submitting an Accident claim)

2.1Please state the date, time and place of the accident	Date (DD/MM/YY):	
	Time:	
	Place of Accident	
2.2 Please describe how the accident happened (Please enclose a copy of the police report, if any)		
2.3 Please describe the injuries sustained		
2.4 Please state the Name and Address of the doctor(s) consulted, and date of consultation(s)	Name of Doctor(s) and address	Date of consultation
2.5Please state the reason if you did not seek treatment immediately after the accident.		

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Details of Illness (Complete this section if you are submitting an Illness claim)

3.1 Please describe the symptoms experienced.		
3.2 Date symptoms first started	Date (DD/MM/YY):	
3.3 Date of first consultation	Date (DD/MM/YY):	
3.4 Please state the Doctor's Diagnosis		
3.5 Please state the date the diagnosis was first made	Date (DD/MM/YY):	
3.6 Please state the Name and Address of the doctor(s) consulted, and date of consultation(s)	Name of Doctor(s) and address	Date of Consultation
3.7 Has the illness been treated previously? (If yes, please stated the dates, name and address of the attending doctor for previous treatment	Name of Doctor(s) and address	Date of consultation

Other Information (Complete this section if you were hospitalised)

4.1 Date of Hospitalisation	Period of Hospitalisation	
	Date of Hospital admission (Date (DD/MM/YY))	Date of Hospital discharge (Date (DD/MM/YY))
4.2 Date of medical leave	From (Date (DD/MM/YY))	To (Date (DD/MM/YY))

4.3 Was any surgery done for this condition? If Yes, please provide details	Surgical operation or procedure	Date of operation or procedure (dd/mm/yyyy)

4.4 Are you claiming from other sources (Accident benefit, Hospitalisation benefit or Medical Expenses)? If yes, please provide the details)	Name of Insurance company, employer, third party	Nature of claim and amount	Policy number

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Supporting documents

The below documents which have been marked need to be enclosed with the claim form.

	Claim Type (Please tick appropriate box)	Additional Documents to be enclosed
☐	**Accidental Dismemberment / Permanent Disablement**	▪ Newspaper article (if available) ▪ Police Report (if available) ▪ Letter from your employer (If accident happened at work place) ▪ Medical Specialist Report ▪ X-ray /imaging reports.
☐	**Medical Reimbursement/Traditional Chinese Medicine** (Applicable for Millennium Comprehensive Personal Accident Benefit, Comprehensive Personal Accident Benefit, PRUPersonal Accident and Accident Assist Benefit)	▪ Original final hospital / medical bills & receipts ▪ Medical Specialist Report
☐	**Weekly Income / Temporary Disablement** **(**Applicable for Personal Accident Benefit, Millennium Comprehensive Personal Accident Benefit and Comprehensive Personal Accident Benefit)	▪ A copy of the Medical Certificates (MC) ▪ Medical Specialist Report
☐	**Weekly Hospital / Hospital Cash / Medical Cash** (Applicable for Weekly Hospital Benefit/Hospital Cash/Medical Cash Benefit/ PruMedical Cash Benefit)	▪ A copy of the final hospital bills shows admission and discharge date ▪ Medical Specialist Report
☐	**Daily Accidental Hospital Income/ICU** (Applicable for Recovery Aid Benefit of PruPersonal Accident and Accident Assist Benefit)	▪ A copy of the final hospital bills shows admission and discharge date ▪ Medical Specialist Report
☐	**Mobility Aid** (Applicable for Fracture Care PA Benefit, Recovery Aid Benefit of PruPersonal Accident and Accident Assist Benefit)	▪ Written Prescription for purchase of mobility aid ▪ Original medical bills & receipts ▪ Medical Specialist Report
☐	**Get Well Transport** (Applicable for Recovery Aid Benefit of PruPersonal Accident and Accident Assist Benefit)	▪ Original transportation bill & receipt ▪ Medical Specialist Report
☐	**Fractures/Dislocations/Burns** (Applicable for Fracture Care PA Benefit)	▪ A copy of the x-ray report for Fracture and Dislocation. ▪ A copy of Burn report for Burns ▪ Medical Specialist Report
☐	**House Fitting Benefit** (Applicable for Fracture Care PA Benefit)	▪ Written Prescription for purchase of mobility aid ▪ Original tax invoices ▪ Medical Specialist
☐	**Recovery Benefit** **(Applicable for Fracture Care PA benefit)**	▪ A copy of the final hospital/medical bills ▪ Medical Specialist Report

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Name of Life Assured:	NRIC / Passport No. of Life Assured:

DECLARATION

1. I hereby declare that the information that is disclosed on this form is to the best of my knowledge and belief, true, complete and accurate, and that no material information has been withheld or is any relevant circumstances omitted. I agree that if I have provided any false or fraudulent information, or suppressed, concealed and/or falsely stated any material facts with regard to this claim, the policy shall be void and all rights of recovery in respect of past or future claims shall be forfeited.
2. I acknowledge and accept that Prudential Assurance Company Singapore (Pte) Limited ("PACS") shall be at liberty to deny liability or recover amounts paid, whether wholly or partially, if any of the information disclosed on this form is incomplete, untrue or incorrect in any respect, or if the policy does not provide cover on which such claim is made.
3. I understand and agree that the submission of this form does not mean that my request will be processed, and that any payout under the policy shall be in PACS sole and absolute discretion. I further acknowledge and agree that the furnishing this form or other supplemental forms by PACS is neither an admission that there was any insurance in force on the life in question, nor an admission of liability nor a waiver of any of its rights or defences.
4. I hereby warrant and represent that I have been properly authorised by the policyholder and the applicable insured(s) to submit information pertaining to such insured's claims.
5. I acknowledge and accept that PACS expressly reserves its rights to require or obtain further information and documentation as it deems necessary. I acknowledge that I am solely responsible for the costs of providing such information and documentation as requested by PACS.
6. I confirmed that I have paid in full all the bill(s)/invoice(s)/receipt(s) that I have submitted to PACS for reimbursement and have not claimed and do not intend to claim from other company(ies)/person(s).
7. I agree to produce all original document(s) that were submitted for reimbursement to PACS for verification as it deems necessary.
8. For the purposes of (i) assessing, processing and/or investigating my claim(s) arising under the Policy or any of my other polic(ies) of insurance with PACS and such other purposes ancillary or related to the assessing, processing and/or investigating of such claim(s); (ii) administering the Policy, (iii) customer servicing, statistical analysis, conducting customer due diligence, reporting to regulatory or supervisory authorities, auditing and recovery of any debts owing to PACS whether in relation to the Policy or any of my other polic(ies) of insurance with PACS, (iv) storage and retention, (v) meeting requirements of prevailing internal policies of PACS, and/or (vi) as set out in PACS Privacy Notice ("**Purpose**"), I authorise, agree and consent to:
    a. Any person(s) or organisation(s) that has relevant information concerning the policyowner and the insured person(s) (including any medical practitioner, medical/healthcare provider, financial service providers, insurance offices, government authorities/regulators, statutory boards, employer, or investigative agencies) ("**Person(s)/Organisation(s)**"), to disclose, release, transfer and exchange any information with PACS and its related corporations, respective representatives, agents, third party service providers, contractors and/or appointed distribution/business partners (collectively referred to as "**Prudential**"), including without limitation, personal data, medical information, medical history, employment and financial information, including the taking of copies of such records; and
    b. Prudential collecting, using, disclosing, releasing, transferring and exchanging personal data about me, the policyowner and the insured person(s), with the Person(s)/Organisation(s), PACS's related group of companies, third party service providers, insurers, reinsurers, suppliers, intermediaries, lawyers/law firms, other financial institutions, law enforcement authorities, dispute resolution centres, debt collection agencies, loss adjustors or other third parties for the Purpose.
9. Where any personal data ("**3rd Party Personal Data**") relating to another person ("**Individual**") (including without limitation, insured persons, family members, and beneficiaries) is disclosed by me or permitted by me to be disclosed in accordance with Clause 8 above, I represent and warrant that I have obtained the consent of the Individual for Prudential to collect and use the 3rd Party Personal Data and to disclose the 3rd Party Personal Data to the persons enumerated above, whether in Singapore or elsewhere, for the Purpose stated above and in PACS Privacy Notice.
10. I understand that I can refer to PACS Privacy Notice, which is available at https://www.prudential.com.sg/Privacy-Notice for more information on contacting PACS for Feedback, Access, Correction and Withdrawal of using my/our personal data. I understand that if I am an European Union ("EU") resident individual (i.e. my residential address is based in any of the EU countries), I can refer to PACS Privacy Notice for more information on the rights available to me under the GDPR.
11. I agree to indemnify Prudential for all losses and damages that Prudential may suffer in the event that I am in breach of any representation and warranty provided to me herein.
12. I agree to receive communication on the claim by email, SMS and/or hard copies by post.
13. I agree that this (i) Prudential shall have full access to the information stated in this form, and (ii) this authorisation and declaration shall form part of my proposed application for the relevant insurance benefits, and a photocopy of this form shall be treated as valid and binding as if it were the original.

Date & Signature of Life Assured above age 18 years

Date & Signature of Policyowner

Relationship to Life Assured

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MEDICAL REPORT

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

Name of Patient		NRIC No.
Patient's Occupation, Name of Employer and Company Address		
Name of Specialist		MCR No.
Field of Specialty		
Name of Medical Institution		

Details of Accident/Illness		
1. Please circle the conditions to which this medical report relates.	☐ Accident	☐ Illness
2. If patient was treated for conditions relating to an Accident, please state the Date of Accident If this is for an illness, please provide Date of First consultation.	Date : dd/mm/yy	
3. Please describe how the accident happen Please state the Symptoms and duration of symptoms experienced by the patient.		
4. Details, nature and extent of injury sustained. What is the underlying cause of the patient's condition?		
5. What is your Diagnosis?		
6. Was the injury sustained consistent with the accident described above? Was the Symptoms presented and Duration of symptoms consistent with your diagnosis. If NO, please elaborate.		
7. Was the injury caused solely by the accident described above? If No, please elaborate.		

Signature & Practice Stamp of the Medical Specialist who filled up Medical Report Date : (dd/mm/yy)

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Name of Patient		
8. Was the accident or Injury or medical condition as a result of a self-inflicted injury, suicide, drug addiction or abuse, alcohol abuse, STD, childbirth, pregnancy or miscarriage. If Yes, please elaborate.		
9. Was the patient referred to you for further management? If yes, please provide us with a copy of the referral letter.		
10. Was the patient hospitalized? If yes, please state the period of hospitalization.	Date of Admission (dd/mm/yy)	Date of Discharge (dd-mm-yy)
11. Please provide details on the type of treatment and/ or surgery performed Please provide copies of all diagnostic and/or laboratory test results.	Treatment/Surgical Operation / Procedure	Date(s) of Treatment /Operation / Procedure (dd/mm/yy)
12. Was medical certificate issued? If yes, please state the period of medical leave issued?	From (dd/mm/yy)	To (dd/mm/yy)
13. Would the injuries prevent the patient from engaging in his/her occupation? If Yes, please elaborate.		
14. Has the patient fully recovered from the injuries?		
15. If Yes, please state the date patient return to work. (dd-mm-yy) If No, please state the date patient is expected to return to work		
16. Was the patient suffering from any illness which would likely contribute or prolonged the period of disability? If Yes, please state.		
17. Any information you may provide which will assist in our assessment of the claim.		
Signature & Practice Stamp of the Medical Specialist who filled up Medical Report		Date : (dd/mm/yy)

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