# CRISIS COVER KIDS CLAIM FORM

**Important Notes**

1. 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.
2. The issue of this form is in no way an admission of liability. No claim can be considered unless the medical specialist report section is furnished at the expense of the claimant.
3. The Company reserves the rights to request for additional documents when deemed necessary.

## PART I

**(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)**

### DETAILS OF POLICY

Policy Number(s) the benefit(s) you would like to claim:

### DETAILS OF LIFE ASSURED

| | | | | | |
|---|---|---|---|---|---|
| Full Name | | | | | |
| NRIC / Passport No. | | Date of birth | | Gender | |
| Address | | | | | |
| Contact No. | | | Email address | | |
| Occupation | | | Name and address of Employer | | |

### TYPE OF CLAIM

1. Please tick [√] in the appropriate box for the critical illness you are claiming on the above policy(ies).

| | | |
|---|---|---|
| ☐ Severe Asthma | ☐ Major Head Trauma | ☐ Brain Surgery |
| ☐ Loss of Limbs | ☐ Leukaemia | ☐ Bone Marrow Transplant |
| ☐ Insulin-dependent Diabetes Mellitus | ☐ Rheumatic Fever with Valvular Impairment | ☐ Kawasaki Disease with Heart Complications |
| ☐ Severe Juvenile Rheumatoid Arthritis | ☐ Glomerulonephritis with Nephrotic Syndrome | ☐ Severe Epilepsy |

### DETAILS OF ILLNESS / MEDICAL CONDITION

2. Describe fully the signs or symptoms for which Life Assured has consulted doctor or received treatment.

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| 3. Date when signs or symptoms first started | | DD | | MM | | YY |

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| 4. Date when Life Assured first consulted a doctor for the above signs or symptoms. | | DD | | MM | | YY |

5. Please provide the following details accordingly if the consultation was due to illness or accident.

| If consultation was for illness, describe fully the nature and extent of illness in terms of its diagnosis and treatment received. | If consultation was due to accident, describe fully the date of accident, how and where did the accident occur. | | |
|---|---|---|---|
| | Was the accident reported to the police? | Yes | No |
| | If yes, please provide:<br>• the name of police officer and police station at which the accident was reported; and<br>• a copy of the police report. | | |

| | | |
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| 6. Has Life Assured previously suffered from or received treatment for a similar or related illness / injury? | Yes | No |

If yes, please give details.

7. Please provide the details of all doctors or specialists whom Life Assured has consulted in connection with his/her illness/injury:-

| Name of Doctor | Name and Address of Clinic / Hospital | Dates of consultation | Reason(s) for consultation |
|---|---|---|---|
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8. Please provide the details of Life Assured's regular doctor and company doctor whom he/she has consulted for minor ailments (e.g. flu, cough, fever), high blood pressure, high cholesterol, diabetes etc.:-

| Name of Doctor | Name and Address of Clinic / Hospital | Dates of consultation | Reason(s) for consultation |
|---|---|---|---|
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| | | | |
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**OTHER INSURANCE**

9. Does Life Assured have similar benefits with any other company? If yes, please give full details :-

| Name of Insurer | Type of Plan | Date of Issue | Sum Assured |
|---|---|---|---|
| | | | |
| | | | |
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**PAYMENT METHOD FOR CLAIM SETTLEMENT**

10. Please tick one of the boxes below to indicate your preferred payment method.

☐ Cheque to be mailed directly to Policyowner address

☐ Cheque to be collected by Prudential Financial Consultant

☐ Cheque to be mailed directly to Prudential Financial Consultant at Agency

Name and Contact No. of your appointed Prudential Financial Consultant:

☐ Direct credit of proceeds into Policyowner's SGD dollar bank account
**(*if you select this payment mode, you need to submit a copy of the bank book or bank statement stating account holder name and number*)**

| Name of Bank | Branch of Bank | Bank Account Number | Name of Account Holder |
|---|---|---|---|

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

## DECLARATION

1. I understand and agree that the submission of this form does not mean that my request will be processed. I understand that any payout under the policy shall be strictly in accordance with the policy terms and conditions.

2. 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 further 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 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.

4. I acknowledge and accept that the furnishing of this form, or any other forms supplemental thereto, 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 and defenses.

5. I acknowledge and accept that PACS expressly reserves its rights to require or obtain further information and documentation as it deems necessary.

6. I confirm 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 bill(s)/invoice(s)/receipt(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 and signature of Life Assured<br>(Policyowner to sign if Life Assured is below age 18 years) | Date and signature of Policyowner |
|---|---|

Name of Patient: NRIC / Passport No. of Patient:

# PART II - MEDICAL SPECIALIST REPORT
## CRISIS COVER KIDS
**(To be completed by the Life Assured's attending medical specialist)**

Please tick [√] in the appropriate box and complete the relevant sections in respect to the critical illness benefit.. Please submit ONLY the relevant sections to us upon completion.

| | | Sections to completed | | | Sections to completed |
|---|---|---|---|---|---|
| ☐ | Severe Asthma | 1, 2 & 14 | ☐ | Major Head Trauma | 1, 3 & 14 |
| ☐ | Brain Surgery | 1, 4 & 14 | ☐ | Loss of Limbs | 1, 5 & 14 |
| ☐ | Leukaemia | 1, 6 & 14 | ☐ | Bone Marrow Transplant | 1, 7 & 14 |
| ☐ | Insulin-dependent Diabetes Mellitus | 1, 8 & 14 | ☐ | Rheumatic Fever with Valvular Impairment | 1, 9 & 14 |
| ☐ | Kawasaki Disease with heart complications | 1, 10 & 14 | ☐ | Severe Juvenile Rheumatoid Arthritis | 1, 11 & 14 |
| ☐ | Glomerulonephritis with Nephrotic Syndrome | 1, 12 & 14 | ☐ | Severe Epilepsy | 1, 13 & 14 |

| | | | |
|---|---|---|---|
| Name of Specialist | | MCR No. | |
| Field of Specialty | | | |
| Name of Medical Institution | | | |

**SECTION 1 : GENERAL INFORMATION**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. Date when patient first consulted you for the condition? | | DD | | MM | | YY |
| 2. When was the last consultation? | | DD | | MM | | YY |
| 3. What were the presenting symptoms when you first saw the patient? | | | | | | |
| 4. When did the above symptoms first present? | | DD | | MM | | YY |
| 5. Please provide exact diagnosis: | | | | | | |
| 6. What is/are the underlying cause(s)? | | | | | | |
| 7. Date of diagnosis | | DD | | MM | | YY |
| 8. Date when patient/patient's next of kin first informed of the diagnosis. | | DD | | MM | | YY |

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|---|---|
| Signature & Practice Stamp of the Medical Specialist who filled up **Part II** | Date |

Name of Patient: NRIC / Passport No. of Patient:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 9. Please provide dates and details of investigation performed for the diagnosis. Kindly attach copies of all relevant objective test reports, which confirmed the diagnosis. | | | | | | | |
| 10. Were you the doctor who first diagnosed the patient with this condition? Please circle. | | | | | | Yes | No |
| 11. If Yes, over what period do your records extend? | | | From (dd/mm/yy) | | | To (dd/mm/yy) | |
| 12. If you are not the first doctor who diagnosed the patient with this condition, please provide: | | | | | | | |
| a. Name and practice address of the doctor who first made the diagnosis or had treated the patient for this condition: | | | | | | | |
| b. Date the diagnosis was made by the previous doctor. | | DD | | MM | | | YY |
| c. When was the referral made for the patient to see you? | | DD | | MM | | | YY |
| d. What was the reason for referral to see you? Please attach a copy of the referral letter. | | | | | | | |
| **SECTION 2 : SEVERE ASTHMA** | | | | | | | |
| 1. When was patient diagnosed to have Severe Asthma? | | DD | | MM | | | YY |
| 2. Please provide a description of the extent of patient's Severe Asthma. | | | | | | | |
| 3. What treatment has been prescribed? | | | | | | | |
| 4. Name and practice address of the doctor that the patient is seeing for management of his/her asthma. | | | | | | | |
| 5. Is the patient's condition acute or chronic? Please circle. | | | **Acute** | | | **Chronic** | |
| 6. In clinical terms, is the patient's condition mild, moderate or severe? Please describe and provide details regarding the severity of the condition. | | | | | | | |
| 7. Was there evidence of an acute attack of severe asthma requiring mechanical ventilation for a continuous period of at least 4 hours to establish control of the asthma? If Yes, please provide following details. | | | | | | Yes | No |
| a. Please specify date of attack? | | DD | | MM | | | YY |

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| Signature & Practice Stamp of the Medical Specialist who filled up **Part II** | Date |

Name of Patient: NRIC / Passport No. of Patient:

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|---|---|---|
| b. Please state the number of hours patient was put on mechanical ventilation? | | hours |
| 8. Is patient currently on any treatment to keep the asthma under control? If Yes, please advise the following: | Yes | No |
| a. Is the patient on continuous daily usage of oral corticosteroids to control asthma? | Yes | No |
| b. If Yes to Q8(a), please advise for how long has the patient been on oral corticosteroids? | | months |
| 9. Does the patient exhibit Harrison's sulcus chest deformity? | Yes | No |
| 10. Does the patient have significant growth impairment due to asthma? | Yes | No |
| 11. Is there growth impairment evidenced in the patient's height falling below the third percentile for his/her age and gender group for a child with asthma whose height has previously been recorded at or above the fifth percentile at a routine developmental examination? | Yes | No |
| a. Please state patient's age at this examination | | years |
| 12. Have patient ever been admitted to hospital in the past 24 months due to control acute attacks of asthma? If Yes, please give full details. | Yes | No |

| Date of admission (dd/mm/yy) | Date of discharge (dd/mm/yy) | Duration of stay (in days) | Name of Hospital |
|---|---|---|---|
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| 13. Is there significant and persistent limitation of the peak expiratory flow rate? | Yes | No |

a. If Yes, please provide details of all recordings of the patient's peak expiratory flow rate below. The recordings must be made on at least 4 occasions at intervals of no less than 1 month in a period of at least 12 months.

| Date of recording | Maximum peak expiratory flow rate | Is rate less than 80% or the rate predicated for a child of the same age, sex and build? |
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| b. Was the patient complying with optimal prescribed asthma medication throughout the period of these recordings? | Yes | No |
| c. Please state the asthma medications prescribed. | | |

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| Signature & Practice Stamp of the Medical Specialist who filled up **Part II** | Date |

Name of Patient: NRIC / Passport No. of Patient:

| **SECTION 3 : Major Head Trauma** | | | | | | |
|---|---|---|---|---|---|---|
| 1. What is date of accident resulting in major head trauma? | | DD | | MM | | YY |
| 2. Where and how did the accident happen leading to major head trauma? | | | | | | |
| 3. Is there reason to suspect that there were contributory circumstances which led to the injury, e.g. under the influence of alcohol, drugs, fits, etc.? | | | | | Yes | No |
| If Yes, please provide details. (e.g. result of blood alcohol concentration, alcohol breath test; name of drugs, quantity consumed, etc.) | | | | | | |
| 4. Was there a police report made with regard to this accident? If Yes, please provide a copy. | | | | | Yes | No |
| 5. Was the head injury due to a self-inflicted act? | | | | | Yes | No |
| 6. Was the head injury due to participation or attempted participation in an unlawful act? | | | | | Yes | No |
| 7. Was there any form of neurological deficit still present 6 weeks after the date of accident? | | | | | Yes | No |
| If Yes, please state the neurological deficits(s). | | | | | | |
| 8. Is the neurological deficit described in Q7 likely to be permanent (i.e. lasting throughout patient's lifetime)? | | | | | Yes | No |
| a. If Yes, please support your basis with evidence. | b. If No, please state date of recovery or date which the patient is expected to recover from neurological deficit. (dd/mm/yy) | | | | | |
| 9. Please give details of any loss of intellectual capacity. | | | | | | |
| 10. What is the extent of the patient's expected recovery from this intellectual loss? | | | | | | |
| 11. Is the intellectual loss permanent? Please elaborate to support the basis. | | | | | | |
| 12. Please provide details of any tests done to assess intellectual capacity, e.g. IQ or Denver Development Screening Tests. | | | | | | |

| Signature & Practice Stamp of the Medical Specialist who filled up **Part II** | Date |
|---|---|

Name of Patient: NRIC / Passport No. of Patient:

| **SECTION 4 : BRAIN SURGERY** | | | | | | |
|---|---|---|---|---|---|---|
| 1. When were you first consulted for the condition requiring surgery? | | DD | | MM | | YY |
| 2. At that time, how long had symptoms been present? | | | | | | |
| 3. Please provide full and exact details of the diagnosis of the condition requiring surgery. | | | | | | |
| 4. Please provide date of diagnosis? | | DD | | MM | | YY |
| 5. Please give details of the nature and type of surgery performed. | | | | | | |
| 6. Please provide date of surgery? | | DD | | MM | | YY |
| 7. Was a craniotomy performed? | | | | | Yes | No |
| 8. Was the surgery a burr hole surgery to remove a blood clot? | | | | | Yes | No |
| 9. Was the condition requiring surgery a result of an accident? If Yes, please provide the following: | | | | | Yes | No |
| Please provide date of accident? | | DD | | MM | | YY |
| Please describe where and how did the accident occur? | | | | | | |

| **SECTION 5 : LOSS OF LIMBS** | | | | | | |
|---|---|---|---|---|---|---|
| 1. What was the diagnosis of the underlying disease/illness leading to the patient's permanent loss of use of limbs. | | | | | | |
| 2. Please provide the diagnosis date of the underlying condition leading to or relating to it. | | DD | | MM | | YY |
| 3. Is there total and irreversible loss of use of two or more limbs? | | | | | Yes | No |
| a. If Yes, please state the number and which are the affected limbs? | | | | | | |
| 4. What is the extent to which the patient is now able to use each affected limb? | | | | | | |

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| Signature & Practice Stamp of the Medical Specialist who filled up **Part II** | Date |

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|---|---|---|---|---|---|---|---|
| 5. Do you expect the affected limb(s) to recover further? | | | | | | Yes | No |
| a. If Yes, what is the extent of recovery in each limb? | | | | | | | |
| 6. Do you expect the affected limb(s) to recover completely? | | | | | | Yes | No |
| a. If Yes, when is it expected? | | DD | | MM | | | YY |
| 7. Is there documentation of the loss of use of the affected limbs for a continuous period of at least six months? | | | | | | Yes | No |
| a. If Yes, please provide the results of investigations done including the six months' period of documentation. | | | | | | | |

**SECTION 6 : LEUKAEMIA**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. Please provide the histological diagnosis and a description of the extent of the illness. | | | | | | |
| 2. Please provide date of diagnosis. | | DD | | MM | | YY |
| 3. Please provide details of any chemotherapy or radiotherapy treatment provided including dates and types of treatment provided. | | | | | | |
| 4. Please provide details of all investigations performed and treatment prescribed. Please attach a copy of the laboratory/Histology investigation results. | | | | | | |

**SECTION 7 : BONE MARROW TRANSPLANT**

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|---|---|---|---|---|---|---|
| 1. Please describe the exact details of the patient's condition. | | | | | | |
| 2. What was the diagnosis of the underlying disease leading to the bone marrow transplant? | | | | | | |
| 3. Date when the patient was first diagnosed of the underlying disease. | | DD | | MM | | YY |
| 4. Please provide the full details of bone marrow transplant performed. | | | | | | |

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| Signature & Practice Stamp of the Medical Specialist who filled up **Part II** | Date |

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|---|---|---|---|---|---|---|---|
| 5. Please give details of the type of treatment provided including dates. | | | | | | | |
| 6. Date the patient was on the waiting list for the transplant. | | DD | | MM | | YY | |
| 7. When did patient actual undergo the transplant of bone marrow? | | DD | | MM | | YY | |
| 8. Name and address of surgeon who performed the transplant and the Hospital where the surgery was performed. | | | | | | | |
| 9. Please give full details of all investigations performed in relation to this condition and their results. | | | | | | | |

**SECTION 8 : INSULIN DEPENDENT DIABETES MELLITUS**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. Please provide full and exact details of the diagnosis of Insulin Dependent Diabetes Mellitus. | | | | | | |
| 2. Please provide date of diagnosis. | | DD | | MM | | YY |
| 3. Was the patient dependent on exogenous insulin? If Yes, please provide the following: | | | | | Yes | No |
| a. How long has the patient been dependent on exogenous insulin? Please provide date of onset of dependence. | | | | | | |
| b. Is there evidence that patient's dependence on exogenous insulin has persisted for a continuous period of at least six months? | | | | | Yes | No |
| c. What are the types of insulin used by the patient? Please provide brand name. | | | | | | |
| d. Please provide details on dosage and frequency and sites of insulin injection. | | | | | | |
| 4. Please provide details on results of blood or urine testing. If possible, please also give the HbA1c results. | | | | | | |
| 5. Please provide details with dates of instances where the patient had diabetic coma. | | | | | | |

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| Signature & Practice Stamp of the Medical Specialist who filled up **Part II** | Date |

Name of Patient: NRIC / Passport No. of Patient:

| SECTION 9 : RHEUMATIC FEVER WITH VALVULAR IMPAIRMENT | | |
|---|---|---|
| 1. Please provide a description of the extent of Rheumatic Fever with Valvular Impairment. | | |
| 2. Please state which of the Jones Criteria for diagnosis of rheumatic fever the patient satisfies. | | |
| 3. Please provide details with supporting evidence of any streptococcal infection. | | |
| 4. Is there any heart valve incompetence? | Yes | No |
| a. If Yes, please state valve(s) involved with details including degree of incompetence. | | |
| b. What is the cause of the heart valve incompetence? | | |
| c. Is the heart valve incompetence attributable to rheumatic fever? | | |
| d. Please provide results of quantitative investigations on heart valve function. | | |
| 5. Please provide details of all investigations performed and treatment prescribed. Please attach a copy of the laboratory investigation results. | | |

| SECTION 10 : KAWASAKI DISEASE WITH HEART COMPLICATIONS | | | | | | |
|---|---|---|---|---|---|---|
| 1. Please provide full and exact details of the diagnosis of Kawasaki with Heart Complication. | | | | | | |
| 2. Please provide date of diagnosis. | | DD | | MM | | YY |
| 3. Is there evidence of dilation or aneurysm formation in the coronary arteries? | | | | | Yes | No |
| a. If Yes, please describe results of investigation and attach a copy of the investigation tests performed confirming this. | | | | | | |
| 4. Please provide details whether there is dilation or aneurysm formation in the coronary arteries. Please enclose copies of investigations performed confirming this. | | | | | | |
| 5. What is the date of onset and duration of the coronary artery dilation or aneurysm formation? | | DD | | MM | | YY |
| 6. Is there evidence of cardiac involvement manifested by dilation or aneurysm formation persisted for at least six months after initial acute episode? | | | | | Yes | No |
| a. If Yes, please provide details and its supporting diagnostic laboratory evidence. | | | | | | |

| Signature & Practice Stamp of the Medical Specialist who filled up **Part II** | Date |
|---|---|

Name of Patient: NRIC / Passport No. of Patient:

| **SECTION 11 : SEVERE JUVENILE RHEUMATOID ARTHRITIS** | | |
|---|---|---|
| 1. Please provide full and exact details of the diagnosis of severe juvenile rheumatoid arthritis. | | |
| 2. Is there evidence of widespread joint destruction with major clinical deformity of the joint areas of: | | |
| a. Hands? | Yes | No |
| b. Wrists? | Yes | No |
| c. Elbows? | Yes | No |
| d. Knees? | Yes | No |
| e. Hips? | Yes | No |
| f. Ankle? | Yes | No |
| g. Cervical Spine? | Yes | No |
| h. Metatarsophalangeal joints in the fee? | Yes | No |
| If Yes to any of the above, please provide more details to your answer, including the onset date of rheumatoid arthritis. | | |
| 3. Is there documentation of the symptoms of arthritis persisted for at least one year after initial episode? | Yes | No |
| If Yes, please provide the results of investigations done including the one year's period of documentation. | | |

| **SECTION 12 : GLOMERULONEPHRITIS WITH NEPHROTIC SYNDROME** | | |
|---|---|---|
| 1. Please confirm if the patient has nephrotic syndrome. | Yes | No |
| If Yes, please advise the duration syndrome has persisted with or without intervening periods of remission. | months | |
| 2. Please describe what are the prescribed treatment regimen appropriate to the clinical presentation to which syndrome relates. | | |
| a. Please state the period of this treatment regimen. | From (dd/mm/yy) | To (dd/mm/yy) |
| b. What is the purpose of this treatment regimen? | | |
| c. Has the patient been following this course of treatment or is the patient non-compliant? | | |
| 3. Please provide the results and attach a copy of investigations done (if any). | | |

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| Signature & Practice Stamp of the Medical Specialist who filled up **Part II** | Date |

Name of Patient: NRIC / Passport No. of Patient:

| **SECTION 13 : SEVERE EPILEPSY** | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. What is the diagnosis date of epilepsy? | | DD | | MM | | YY | |
| 2. How was the diagnosis established? Please include a copy of diagnostic investigation reports (e.g. electroencephalography (EEG), Magnetic Resonance Imaging (MRI), Position Emission Tomography (PET) etc.). | | | | | | | |
| 3. Has the patient experienced recurrent unprovoked tonic-clonic or grand mal seizures? | | | | | | Yes | No |
| a. Was it due to a disorder of the brain? | | | | | | Yes | No |
| b. What is the frequency of attack per week? | | | | | | | |
| 4. Has the patient undergo neurosurgery for treatment of epileptic seizures? | | | | | | Yes | No |
| a. When was neurosurgery performed? | | DD | | MM | | YY | |
| 5. Is the patient taking prescribed anti-epileptic (anti-convulsant) medication? | | | | | | Yes | No |
| a. If Yes, please state the type(s) of medication and period he has been on such medication. | | | | | | | |

| **SECTION 14 : OTHER INFORMATION** | | |
|---|---|---|
| 1. Has the patient's condition resulted in him/her to be physically or mentally disabled from ever continuing in any employment? If Yes, please state: | Yes | No |
| a. What were the patient's main physical or mental impairment and the severity of these limitations | | |
| b. What is your reason that the patient is incapable of any employment throughout his/her lifetime? | | |
| c. In accordance to the Singapore's Mental Capacity Act (Cap 177A), is the patient mentally incapacitated? | Yes | No |
| 2. Is the patient's condition or surgery performed in any way related or due to:- | | |
| a. AIDS, AIDS-related complex or infection by HIV? | Yes | No |
| b. Drug abuse or use of drug not prescribed by registered medical practitioner? | Yes | No |
| c. Alcohol abuse or misuse? | Yes | No |
| d. Congenital anomaly or defect? | Yes | No |

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| Signature & Practice Stamp of the Medical Specialist who filled up **Part II** | Date |

Name of Patient: NRIC / Passport No. of Patient:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| e. Attempted suicide or self-inflicted injuries? | | | | | | Yes | No |
| **If Yes for any of the above, please provide the following details and also attach a copy of the test result.** | | | | | | | |
| f. Please indicate the diagnosis date. | | DD | | MM | | | YY |
| g. Name and practice address of the doctor who first diagnosed the patient with HIV, AIDS, drug abuse, alcohol abuse or congenital anomaly. | | | | | | | |
| 3. Has the patient previously suffered from or received treatment for a similar/related illness? If Yes, please provide the following details. | | | | | | Yes | No |

| Diagnosis | Date of diagnosis | Date when patient was informed of diagnosis | Name and date of treatments | Name and address of treating doctor |
|---|---|---|---|---|
| | | | | |

| | | |
|---|---|---|
| 4. Is there anything in the patient's medical history which would have increased the risk of his/her condition? | Yes | No |
| If Yes, please state the details. | | |
| 5. Does the patient have or ever had any other significant health condition? If Yes, please provide the following details. | Yes | No |

| Diagnosis | Date of diagnosis | Date when patient was informed of diagnosis | Name and date of treatments | Name and address of treating doctor |
|---|---|---|---|---|
| | | | | |

| | | |
|---|---|---|
| 6. Is there anything in the patient's medical history which would have increased the risk of his/her condition? | Yes | No |
| If Yes, please state the details. | | |
| 7. Does the patient have or ever had any other significant health condition? If Yes, please provide the following details. | Yes | No |

| Diagnosis | Date of diagnosis | Date when patient was informed of diagnosis | Name and date of treatments | Name and address of treating doctor |
|---|---|---|---|---|
| | | | | |

| | |
|---|---|
| Name and Signature of the Medical Specialist who filled up **Part II** | Date |
| Practice Stamp of the Medical Specialist | |

# PART III
# 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.

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