FEMALE BENEFIT CLAIM FORM
(PRUSMART LADY & PRULADY)

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)

1. DETAILS OF POLICY

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

2. DETAILS OF LIFE ASSURED

Full Name		NRIC No.	
Address		Contact No.	
Date of birth	(DD/MM/YYYY)	Occupation	

3. TYPE OF CLAIM

3.1 Please tick the appropriate box for the Female Illness / Medical Conditions you are claiming.

FEMALE ILLNESS		FEMALE ILLNESS		RECONSTRUCTIVE SURGERY	
Systemic Lupus Erythematosus (SLE) with Lupus Nephritis		Pelvic relaxation requiring surgical repair		Facial reconstructive surgery due to an Accident	
Rheumatoid Arthritis		Thyroid disorders causing Thyroid Storm		Skin Grafting due to Major burns	
Chronic Auto-Immune Hepatitis		Polycystic Ovarian Syndrome		**SUPPORT BENEFIT**	
Osteoporosis requiring surgery or repair		**MEDICAL PROCEDURE**		Hormone Replacement Therapy	
Urinary incontinence requiring surgical repair		Complicated repair of a vaginal fistula		Outpatient Psychiatric benefit	
Uterine Prolapse					

4. NATURE OF CLAIM

4.1 Please describe fully the extent and nature of illness.

4.2 Have you previously suffered from or received treatment for a similar or related illness / injury? If yes, please give details.

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4.3 Please provide the details of all the doctors who had attended to you:-

Name of doctor consulted	Address of doctor	Date first consulted for this illness

4.4 Please provide the details of your regular doctor and company doctor whom you have 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 (DD/MM/YYYY)	Reason(s) for consultation

5. OTHER INSURANCE

5 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

6. PAYMENT METHOD FOR CLAIM SETTLEMENT (please tick the appropriate)

☐ 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 bank account
(if you select this payment mode, you need to submit a copy of the bank passbook 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 (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

(To be completed by the life assured's attending medical specialist.

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

SECTION 1

1. Are you the insured's usual doctor?					Yes / No		
2. Over what period do your records extend? Start date: _____ (DD/MM/YYYY) End date: _____ (DD/MM/YYYY)							
3. Date you were first consulted for the condition		DD		MM		YY	
4. What were the presenting symptoms when you first saw the patient?							
5. When did the above symptoms first started?		DD		MM		YY	
If the date is unknown, please state how long the symptoms had been present prior to the date of first consultation.							
6. What was the diagnosis?							
7. Date of diagnosis		DD		MM		YY	
8. Date diagnosis was made known to the patient		DD		MM		YY	
9. What was the exact information regarding the diagnosis that the patient or patient's next of kin was informed on the date stated in (7) above.							
10. 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 and had treated the patient for this condition.							

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

b. Date the diagnosis was made by the previous doctor.
c. If the patient was referred to you for further management, please provide the name and practice address of the referral doctor. Please provide a copy of the referral letter.
11. What medical treatment has the patient been receiving? When did each of the treatment commence?
12. Please provide the name and address of the patient's regular attending doctor.
13. What is the patient's prognosis?

SECTION 2

Please complete Question 1 to 2 if patient's condition is on:
Systemic Lupus Erythematosus (SLE) with Lupus Nephritis

1. Does the patient's current condition require systemic immunosuppressive therapy due to involvement of multiple organs?	Yes	No
Please provide copies of laboratory tests e.g. ANA, Anti-DNA Antibody, ESR confirming the diagnosis of SLE.		
2. If yes to (1), please state if any of the following organs were involved:		
- Heart	Yes	No
- Central Nervous System	Yes	No
- Kidneys	Yes	No
If yes, was renal biopsy performed? Please enclose a copy of the renal biopsy results.	Yes	No

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

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

Please state the class of Lupus Nephritis in accordance with WHO classification. Lupus Nephritis Class I / II / III / IV / V (please circle the appropriate)		
Please complete Question 3 to 5 if patient's condition is on: **Rheumatoid Arthritis**		
3. Was there widespread joint destruction with major clinical deformity of the following joints? Hands/ Wrists / Elbows / Cervical Spine / Knees / Ankles / Metatarsophalangeal joints (please circle the affected areas)		
Please provide a copy of the laboratory reports e.g. X-ray/ ESR/ CRP readings		
4. Did the patient's condition resulted in the inability to perform (whether aided or unaided) her "Activities of Daily Living (ADLs)" for a continuous period of at least 6 months	Yes	No
If yes, please circle the ADLs which she is unable to perform independently Washing / Dressing / Transferring / Mobility / Toileting / Feeding		
5. Please comment on the following in relation to the patient's current disability as a result of her condition:		
a. Is the patient totally and permanently disabled such that she cannot engage in any occupation, business or activity which pays an income?	Yes	No
b. Is the patient permanently disabled and confined to a home, hospital or other institution requiring constant care and medical attention for at least 6 consecutive months?	Yes	No
c. Is the patient suffering from total and irrecoverable loss of use of both eyes?	Yes	No
d. Is the patient suffering from total and irrecoverable loss of use of any 2 limbs at or above the wrist or ankle?	Yes	No
e. Is the patient suffering from total and irrecoverable loss of use of one eye and any one limb at or above the wrist or ankle?	Yes	No
Please complete Question 6 to 8 if patient's condition is on: **Chronic Auto-Immune Hepatitis**		
6. Is there presence of hypergammaglobulinaemia?	Yes	No

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

7. Is there presence of any of the following auto-anitibodies?		
- Anti-Nuclear antibody (ANA)	Yes	No
- Anti-Smooth muscle antibodies	Yes	No
- Anti-actin antibodies	Yes	No
- Antibodies to Liver-Kidney Microsome (Anti-LKM-1)	Yes	No
8. Please advise if a liver biopsy was performed.	Yes	No
If yes, please provide us with a copy of the liver biopsy results confirming the diagnosis of Chronic Auto-Immune Hepatitis		
Please complete Question 9 to 12 if patient's condition is on: Urinary incontinence requiring surgical repair		
9. When did the patient first started on incontinence treatment?		
10. Was the patient on incontinence treatment for a continuous period of at least 6 months?	Yes	No
11. Has surgery been performed for repair of urinary incontinence? If yes, please state the nature of surgery performed and the date the surgery was performed.	Yes	No
12. Was the surgery performed for any causes other than urinary incontinence? If yes, please provide details on the nature of the condition and the date of diagnosis of the condition.	Yes	No
Please complete Question 13 to 18 if patient's condition is on: Uterine Prolapse/ Pelvic Relaxation requiring surgical repair		
13. When was the patient first managed for this condition?		

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

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

14. Was the patient on continuous management for uterine prolapse/ pelvic relaxation for at least 2 years?	Yes	No
15. During this time, was there continuous use of management devices (e.g. vaginal pessary)?	Yes	No
16. Has surgery been performed to correct the loosening of the support muscles and tissues in the pelvic area?	Yes	No
17. Please state the date the surgery was performed.		
18. Was the surgery performed for any causes other than uterine prolapse/ pelvic relaxation? If yes, please provide details on the nature of the condition and the date of diagnosis of the condition.	Yes	No
Please complete Question 19 to 21 if patient's condition is on: **Complicated repair of a vaginal fistula**		
19. Please state the type of vagina fistula		
20. Has surgery been performed to correct the vaginal fistula?	Yes	No
21. If yes, please state the date surgery was performed		
Please complete Question 22 to 24 if patient's condition is on: **Osteoporosis requiring surgery or repair**		
22. Was there evidence of bone density reading of WHO T-score less than 2.5?	Yes	No
If yes, what was the bone density T-score reading		

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

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

23. Did the patient ever required or had undergone any surgery to repair or replace parts of the vertebrae, pelvis, radius, ulna, humerus, tibia or femur as a result of a fracture sustained in the presence of osteoporosis?	Yes	No

24. If yes, please state
    i) the site of the fracture

    ii) the nature of the surgery and the date surgery was performed.

Please complete Question 25 to 27 if patient's condition is on:
Thyroid disorders causing thyroid storm

25. Was there presence of severe and life threatening symptoms stated below

a) Hyperpyrexia	☐ Yes	☐ No
b) Cardiovascular dysfunction (tachycardia, atrial fibrillation, cardiac failure)	☐ Yes	☐ No
c) Altered mentation (agitation, delirium, psychosis, stupor or coma)	☐ Yes	☐ No
d) Gastrointestinal symptoms (nausea, vomiting, abdominal pain)	☐ Yes	☐ No

26. Would you consider this a Thyroid Storm?	Yes	No
27. Was there admission to intensive care unit (ICU)? If yes, please state the duration of stay : _____ days	Yes	No

Please complete Questions 28 to 34 if patient's condition is on:
Polycystic Ovarian Syndrome

28. What is the diagnosis and on which date was the diagnosis made? Diagnosis : _____	Diagnosis date (DD/MM/YYYY)

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

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

29. Was there presence of symptoms stated below?

a) Menstrual Disturbance	☐ Yes	☐ No
b) Hircutisum	☐ Yes	☐ No
c) Acne	☐ Yes	☐ No
d) Anovulatory Infertility	☐ Yes	☐ No

30. Please state the investigations done to confirm the diagnosis.

31. Was there evidence of elevated Luteinizing hormone or testosterone?	Yes	No
32. Was there abnormal / impaired oral glucose tolerance?	Yes	No
33. Did the ultrasound showed increased ovarian area of more than 5.5cm^2 or volume of more than 11mL and/ or presence of at least 12 follicles measuring 2 to 9 mm in diameter in both ovaries?	Yes	No

34. Please provide a copy of all ultrasound and lab reports for the above.

Please complete Question 35 to 40 if the patient's condition is on:
Hormone replacement therapy after oophorectomy and/ or hysterectomy

35. Has the patient undergone oophorectomy and/ or hysterectomy?	Yes	No

36. Please state the nature of the operation and when it was performed
Please also provide a copy of the operation notes/ reports.

37. Is the oophorectomy and/ hysterectomy bilateral?	Yes	No

38. What was the underlying medical condition that led to the said procedure?

39. Was hormone replacement therapy (HRT) advised after the surgery?	Yes	No

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40. Please describe the symptoms that have necessitated the HRT.		
Please complete Question 41 to 46 if the patient's condition is on: Psychiatric condition due to traumatic life event – Disfigurement due to 3rd Degree Burns or Death of spouse or child		
41. Was the patient diagnosed with Major Depressive Disorder (MDD? And/ or Anxiety Disorders?	Yes	No
42. Was the patient's Major Depressive Disorder (MDD) and/ or Anxiety Disorder caused by disfigurement due to 3rd degree burns?	Yes	No
43. Was the patient's Major Depressive Disorder (MDD) and/ or Anxiety Disorder caused by death of spouse?	Yes	No
44. Was the patient's Major Depressive Disorder (MDD) and/ or Anxiety Disorder caused by death of child?	Yes	No
45. What was the treatment prescribed for MDD and/ or Anxiety Disorder?		
46. Was the patient under medication for at least 6 continuous months?	Yes	No
Please complete Question 47 to 58 if the patient's condition is on: Skin grafting due to Major burns and Reconstructive surgery due to an accident		
47. Date of accident: (DD/MM/YYYY)	Place of accident:	
48. Place of accident		
49. Please describe how the accident happened.		
50. Please describe the nature and extend of injuries sustained.		

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

51. Was the accident reported to the police?	Yes	No
52. If yes, please provide the name of the police officer and police station at which the accident was reported and a copy of the police report.		
53. Which areas of the body were affected by burns?		
54. What percentage of the body surface was affected by 3rd degree burns?	%	
55. Did the patient undergo any skin grafting?	Yes	No
56. Please state the date of the surgery and provide a copy of the operation report.	(DD/MM/YYYY)	
57. Did the patient undergo any facial reconstruction due to the accident?	Yes	No
58. If yes, please state the nature of reconstruction performed and the date of the surgery. Please also provide a copy of the operation report.		

SECTION 3

1. Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?	Yes	No
If yes, please provide the date of diagnosis of HIV/ AIDS.	(DD/MM/YYYY)	
2. Is the diagnosis related to a deliberate act of taking intoxicating liquor, drugs or poison, suicide or attempted suicide or intentional self-injury	Yes	No
If yes, please provide details.		

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3. Is the diagnosis related to the use of unprescribed drugs where such drugs are required by law to be prescribed by a registered medical practitioner?	Yes	No
If yes, please provide details.		
SECTION 4		
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 suffering from any significant medical condition? If yes, please provide the following information:	Yes	No
a) Date of diagnosis _____(DD/MM/YYYY) b) Name and practice address of the doctor who had diagnosed/ treated the patient.		
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?		

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

SECTION 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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