FEMALE BENEFIT CLAIM FORM
(PRUSMART LADY, PRULADY, PRUMUM2BE & PRUFIRST PROMISE)

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.

CONGENITAL ILLNESS		CONGENITAL ILLNESS		CONGENITAL ILLNESS	
Down's Syndrome		Anal Atresia		Congenital Deafness	
Spina Bifida		Infantile Hydrocephalus		Trancheo-Esophageal Fistula or Esophageal Atresia	
Tetralogy of Fallot		Cleft Palate/ Cleft Lip & Palate		Patent Ductus Arteriosus	
Transposition of Great Vessels		Cerebral Palsy		Congenital Hypertrophic Pyloric Stenosis	
Atrial Septal Defect		Club Foot		Congenital Diaphragmatic Hernia	
Ventricular Septal Defect		Congenital Dislocation of Hip		Retinopathy of Prematurity	
Absence of Two Limbs		Congenital Blindness		Truncus Arteriosis	
Biliary Atresia		Coarctation of the aorta		Congenital cataract	
Developmental Dysplasia of Hip					

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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.

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.							

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

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.
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:
Down's Syndrome (Trisomy 21 or Mongolism)

1. Is there an extra chromosome 21?	Yes	No
2. Does the child exhibit the following:		
- Muscle hypotonicity	Yes	No
- Microcephaly	Yes	No
- Flattened occiput	Yes	No
- Brachycephaly	Yes	No

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

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

Please complete Question 3 to 4 if patient's condition is on: Spina Bifida		
3. Has there been defective closure of the spinal column due to a neural tube deficit?	Yes	No
4. Was there meningomyelocele or meningocele and associated neurological deficit? If yes to neurological deficit, please specify the nature of neurological deficit.	Yes	No
Please complete Question 5 to 7 if the patient's condition is on: Tetralogy of Fallot		
5. Is there severe or total right ventricular outflow tract obstruction?	Yes	No
6. Is there ventricular septal defect allowing right ventricular unoxygenated blood to bypass the pulmonary artery and enter the aorta directly?	Yes	No
7. Has surgery been performed to correct the condition? If yes, please provide the date of surgery and a copy of the operation report. ---------- (DD/MM/YYYY)	Yes	No
Please complete Question 8 to 11 if the patient's condition is on: Transposition of the Great Vessels		
8. Is there complete transposition of the aorta and pulmonary artery?	Yes	No
9. Does the right ventricle pump blood from the systemic veins into the aorta?	Yes	No
10. Does the left ventricle pump blood from the pulmonary veins into the pulmonary artery?	Yes	No
11. Has surgery been performed to correct the condition? If yes, please provide the date of surgery and a copy of the operation report. ---------- (DD/MM/YYYY)	Yes	No
Please complete Question 12 to 13 if patient's condition is on: Atrial Septal Defect/ Ventricular Septal Defect		
12. Was the diagnosis of Atrial Septal Defect or Ventricular Septal Defect confirmed on echocardiogram?	Yes	No
13. Has surgery been performed to correct the condition? If yes, please provide the date of surgery and a copy of the operation report. ---------- (DD/MM/YYYY)	Yes	No

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

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

Please complete Question 14 to 15 if the patient's condition is on: Absence of Two Limbs		
14. Was the patient born with absence of: - 2 arms (above the wrist); - 2 legs (above the ankle); or - an arm (above the wrist) and a leg (above the ankle) from birth?	Yes	No
15. If yes, please state which were the limbs affected.		
Please complete Question 16 to 17 if patient's condition is on: Anal Atresia		
16. Was there absence of the anus or absence of the canal between the rectum and anus?	Yes	No
17. Has surgery been performed to correct the condition? If yes, please provide the date of surgery and a copy of the operation report. ---------- (DD/MM/YYYY)	Yes	No
Please complete Question 18 to 20 if patient's condition is on: Infantile Hydrocephalus		
18. Was there accumulation of cerebrospinal fluid within the cerebral ventricles?	Yes	No
19. Does the patient require the insertion of an extra-cranial shunt?	Yes	No
20. Is the condition of infantile hydrocephalus arising from congenital, developmental or acquired cause?	Yes	No
Please complete Questions 21 to if patient's condition is on: Cleft Palate and Cleft Lip and Palate		
21. Has surgery been performed to correct the condition? If yes, please provide the date of surgery and a copy of the operation report. ---------- (DD/MM/YYYY)	Yes	No

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

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

Please complete Questions 22 if patient's condition is on: **Cerebral Palsy**		
22. Did the cerebral palsy result from damage to the brain before, during or immediately after birth?	Yes	No
Please complete Question 23 to 24 if patient's condition is on: **Club Foot**		
23. Please advise if the following were present: a) Plantar Flexion b) Inversion of the heel hindfoot and forefoot c) Adduction of the forefoot	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No
24. Was the club foot bilateral?	Yes	No
Please complete Question 25 to 27 if patient's condition is on: **Congenital Dislocation of the Hip**		
25. Was there displacement of the femoral head from the acetabulum of the pelvis?	Yes	No
26. Has surgery been performed to correct the condition? If yes, please provide the date of surgery and a copy of the operation report. ---------- (DD/MM/YYYY)	Yes	No
27. Was the displacement arising from congenital, developmental or accidental causes?	Yes	No
Please complete Question 28 to 29 if patient's condition is on: **Congenital Blindness**		
28. Please confirm if there is complete absence of the sense of sight in both eyes.	Yes	No
29. Was the complete loss of sight arising from congenital, developmental or accidental cause? Please provide evidence where possible to substantiate congenital blindness.	Yes	No

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

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

Please complete Question 30 to 31 if patient's condition is on: **Congenital Deafness**		
30. Please confirm if there is complete absence of the sense of hearing in both eyes.	Yes	No
31. Was the complete loss of sight arising from congenital, developmental or accidental cause? Please provide evidence where possible to substantiate congenital deafness.	Yes	No
Please complete Question 32 to 34 if patient's condition is on: **Trancheo-Esophageal Fistula or Esophageal Atresia**		
32. Was there failure of the esophagus to develop a continuous passage and instead ended as a blind pouch?	Yes	No
33. Was there an abnormal opening between the trachea and esophagus?	Yes	No
34. Has surgery been performed to correct the condition? If yes, please provide the date of surgery and a copy of the operation report. ---------- (DD/MM/YYYY)	Yes	No
Please complete Question 35 to 36 if patient's condition is on: **Patent Ductus Arteriosus**		
35. Was the diagnosis of Patent Ductus Arteriosus confirmed on echocardiogram?	Yes	No
36. Has surgery been performed to correct the condition? If yes, please provide the date of surgery and a copy of the operation report. ---------- (DD/MM/YYYY)	Yes	No

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

Please complete Questions 37 to 38 if patient's condition is on: Congenital Hypertrophic Pyloric Stenosis		
37. Please advise if the following were present:		
a) Thickening of the pylorus	☐ Yes	☐ No
b) Obstruction of the gastric outlet	☐ Yes	☐ No
c) Projectile vomiting	☐ Yes	☐ No
38. Has surgery been performed to correct the condition? If yes, please provide the date of surgery and a copy of the operation report. ---------- (DD/MM/YYYY)	Yes	No
Please complete Questions 39 to 42 if patient's condition is on: Congenital Diaphragmatic Hernia		
39. Was there protrusion of abdominal contents through a developmental defect of the diaphragm into the chest cavity?	Yes	No
40. If yes, was this due to congenital malformation of the diaphragm?	Yes	No
41. Please provide a copy of the chest radiograph report confirming the diagnosis.		
42. Has surgery been performed to correct the condition? If yes, please provide the date of surgery and a copy of the operation report. ---------- (DD/MM/YYYY)	Yes	No
Please complete Question 43 to 45 if the patient's condition is on: Retinopathy of Prematurity		
43. Was the patient diagnosed to have Retinopathy of Prematurity?	Yes	No

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

44. If yes, did the patient undergo laser, cryotherapy or surgical procedure for the condition?	Yes	No
45. Please provide the date of surgery and a copy of the operation report.	(DD/MM/YYYY)	
Please complete Question 46 to 48 if the patient's condition is on: Truncus Arteriosis		
46. Was the diagnosis of Truncus Arteriosis confirmed on echocardiogram?	Yes	No
47. Has an invasive surgery been performed to correct the condition?	Yes	No
48. Please provide the date of surgery and a copy of the operation report.	(DD/MM/YYYY)	
Please complete Question 49 to 52 if the patient's condition is on: Biliary Atresia		
49. Was there a congenital absence of or abnormally narrowed or blocked bile ducts leading to disorder or disease of the liver?	Yes	No
50. Did the baby present with any of the following?		
- Presence of jaundice for 2-3 weeks after birth	Yes	No
- Appearance of jaundice after 2 weeks of birth	Yes	No
- Marked increase of direct bilirubin as evidenced by laboratory report *	Yes	No
- Evidence of biliary atresia on imaging scans or liver biopsy *	Yes	No
* Please provide a copy of the laboratory, scan and liver biopsy report.		
51. Was surgery (either portoenterostomy or liver transplantation) performed? Please state the date of the surgery _____ (DD/MM/YYYY)	Yes	No

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

52. Was the neonatal jaundice or liver disease due to causes other than biliary atresia? Please specify the underlying cause: _____	Yes	No
Please complete Question 53 to 55 if the patient's condition is on: Coarctation of the aorta		
53. When was the patient diagnosed to have coarctation of the aorta?	(DD/MM/YYYY)	
54. Was the diagnosis confirmed on echocardiogram? Please provide us with a copy of the echocardiogram report.	Yes	No
55. Has the patient undergone surgery to correct the condition? Please state the name of the surgical procedure _____ The date the surgery was performed _____(DD/MM/YYYY)	Yes	No
Please complete Question 56 to 58 if the patient's condition is on: Congenital cataract		
56. Does the patient have congenital cataract?	Yes	No
57. When was the diagnosis made?	(DD/MM/YYYY)	
58. Has the patient undergone surgery to correct the condition? Please state the name of the surgical procedure _____ The date the surgery was performed _____(DD/MM/YYYY)	Yes	No

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

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

Please complete Question 59 to 61 if the patient's condition is on: Developmental Dysplasia of Hip		
59. Does the patient have congenital hip dysplasia?	Yes	No
60. When was the diagnosis made?	(DD/MM/YYYY)	
61. Has the patient undergone surgery to correct the condition? Please state the name of the surgical procedure _____ The date the surgery was performed _____(DD/MM/YYYY)	Yes	No
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.		
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.		

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

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

4. Was this pregnancy conceived via any fertility treatment? (please tick as applicable) a) In-vitro fertilization (IVF) ( ) b) Intracytoplasmic sperm injection (ICSI) ( ) c) Intrauterine insemination (IUI) ( ) d) Intracervical insemination (ICI) ( ) e) Other: Please specify _____ If yes, please state the number of foetus conceived: _____	Yes	No
5. Was the patient carrying 3 or more babies in a single pregnancy?	Yes	No
SECTION 4		
1. 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.		
2. 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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