FEMALE BENEFIT CLAIM FORM

(PRUSMART LADY, PRULADY, PRUFIRST GIFT, 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.

PREGNANCY COMPLICATIONS		PREGNANCY COMPLICATIONS		PREGNANCY COMPLICATIONS	
Disseminated Intravascular Coagulation		Fatty Liver of Pregnancy		Placenta Increta/ Pecreta	
Death of foetus after 195 days of pregnancy		Postpartum Hemorrhage requiring Hysterectomy		Uterine rupture	
Death of child within 28 days after birth		Miscarriage due to accident		HELLP syndrome	
Death of life assured during delivery		Anterpartum Hemorrhage		Amniotic Fluid Embolism	
Hydatidiform Mole		Gestational Diabetes Mellitus		Abruptio Placentae	
Pre-Eclampsia or Eclampsia		Still Birth		Psychiatrist/ Psychologist consultation	
Post-partum depression					

4. NATURE OF CLAIM

4.1 Please describe fully the extent and nature of illness.

C170621

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

PART II MEDICAL SPECIALIST REPORT

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

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

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

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

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 4 if patient's condition is on:
Disseminated Intravascular Coagulation (DIC)

1. Did DIC occur as a result of pregnancy?	Yes	No
2. Did DIC occur within first 7 months of pregnancy?	Yes	No

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

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

3. Please state if the following were present:		
- Entrance of uterine material with tissue factor activity into the maternal circulation	Yes	No
- Major hemorrhage	Yes	No
- End organ damage as a result of DIC	Yes	No
- Significant thrombocytopenia, pro-coagulant activation, fibrinolytic activation and inhibitor consumption	Yes	No
- Treatment with frozen plasma and platelet concentrates	Yes	No
4. Was the patient admitted to hospital within 42 days after childbirth? If yes, please state the period of confinement: _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
Please complete Question 5 to 7 if the patient's condition is on: **Ectopic Pregnancy**		
5. Was there implantation of a fertilized ovum outside the uterine cavity?	Yes	No
6. Was the ectopic pregnancy terminated by laparotomy or laparoscopic surgery? If no, please advise how the ectopic pregnancy was terminated. ----------	Yes	No
7. Was the patient admitted to hospital within 42 days after childbirth? If yes, please state the period of confinement: _____ to _____ (DD/MM/YYYY) (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 8 to 10 if the patient's condition is on: Death of Foetus after 195 days of pregnancy		
8. Was there death of foetus after 195 days of gestation? If yes, please the cause of death of the foetus.	Yes	No
9. a. Was the foetus electively terminated or aborted?	Yes	No
b. If yes, was the termination required due to medical reasons? Please specify the reason for termination :	Yes	No
10. Was the patient admitted to hospital within 42 days after childbirth? If yes, please state the period of confinement: _____ (DD/MM/YYYY) to _____ (DD/MM/YYYY)	Yes	No
Please complete Question 11 to 12 if patient's condition is on: Death of child within 28 days after birth		
11. Was there death of child within 28 days of delivery? If yes, please state the cause of death of the child :	Yes	No
12. Was the child alive at the time of delivery?	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 13 to 15 if the patient's condition is on: Hydatidiform Mole		
13. Was the pregnancy characterized with the development of fluid-filled cysts in the uterus after the degeneration of the chorion?	Yes	No
14. Was there death of the embryo?	Yes	No
15. Was the patient admitted to hospital within 42 days after childbirth? If yes, please state the period of confinement: _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
Please complete Question 16 to 19 if patient's condition is on: Pre-Eclampsia or Eclampsia		
16. Was there hypertension developing after 20 weeks of pregnancy?	Yes	No
17. Please provide 2 readings of the highest recorded blood pressure reading taken at least 6 hours apart.		
<u>Reading 1 & date taken</u>	<u>Reading 2 & date taken</u>	
18. Was there associated proteinuria of >3+ on random urine sample or >2.5g in a 24 hours urine specimen?	Yes	No
19. Was the patient admitted to hospital within 42 days after childbirth? If yes, please state the period of confinement: _____ to _____ (DD/MM/YYYY) (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 20 to 24 if patient's condition is on: **Fatty Liver of Pregnancy**		
20. Was there acute liver failure?	Yes	No
21. Was there persistent elevation of bilirubin above 150 umol/L (10 mg/dL) for a period of at least 5 days?	Yes	No
22. If yes, please state the readings taken each day? Date: _____ Reading: _____ Date: _____ Reading: _____ Date: _____ Reading: _____ Date: _____ Reading: _____ Date: _____ Reading: _____		
23. Was there associated hepatic encephalopathy?	Yes	No
24. Was the patient admitted to hospital within 42 days after childbirth? If yes, please state the period of confinement _____ to _____ (DD/MM/YYYY) (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 25 to 26 if patient's condition is on:
Amniotic Fluid Embolism

25. Please advise if the following were present:

a) Respiratory Distress	☐ Yes	☐ No
b) Cardiovascular Collapse	☐ Yes	☐ No
c) Disseminated Intravascular Coagulation	☐ Yes	☐ No
d) Coma	☐ Yes	☐ No
e) Pulmonary Embolism as evident on lung scans	☐ Yes	☐ No

26. Was the patient admitted to hospital within 42 days after childbirth? If yes, please state the period of confinement _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No

Please complete Question 27 to 31 if patient's condition is on:
Abruptio Placentae

27. When is the expected date of delivery?	(DD/MM/YYYY)	
28. Did abruptio placentae occur after the 20th week of gestation and prior to birth of the foetus?	Yes	No
29. Was there life threatening fetal distress leading to maternal shock?	Yes	No
30. Were there Class 2 or Class 3 abruptio?	Yes	No
31. Was the Caesarian section performed an emergency or planned surgery? 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

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

Please complete Question 32 to 35 if patient's condition is on: Postpartum Hemorrhage requiring Hysterectomy		
32. Please advise if there was ongoing bleeding following delivery.	Yes	No
33. If yes, was the bleeding due to an unresponsive and atonic uterus, ruptured uterus or large cervical laceration extending into the uterus?	Yes	No
34. Was hysterectomy performed as a result of the postpartum hemorrhage If yes, please provide a copy of the operation report/ notes.	Yes	No
35. Was the patient admitted to hospital within 42 days after childbirth? If yes, please state the period of confinement _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
Please complete Questions 36 to 42 if patient's condition is on: Miscarriage due to Accident		
36. Please state the date of accident and describe how the accident happened. How the accident happened:	Accident date (DD/MM/YYYY)	
37. Please provide a copy of the police statement of this accident.		
38. Please state if the accident has led to a miscarriage	Yes	No
39. If yes, please state the date where the miscarriage took place.	(DD/MM/YYYY)	
40. Please state the duration of the pregnancy at the time of miscarriage.	(number of weeks)	

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

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

41. Were there any causes other than the accident that may have caused the miscarriage?	Yes	No
a. If yes, please state the date of diagnosis of the condition stated in (Q41) _____ (DD/MM/YYYY) b. Name and address of the doctor who made the diagnosis:		
42. Was the patient admitted to hospital within 42 days after childbirth? If yes, please state the period of confinement _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
Please complete Question 43 to 47 if the patient's condition is on: Antepartum Hemorrhage		
43. Please state the underlying cause of the antepartum hemorrhage.		
44. Was there genital bleeding during pregnancy after 28 weeks of pregnancy?	Yes	No
45. If yes, did the bleeding led to loss of foetus or hysterectomy?	Yes	No
46. Was hysterectomy performed as a result of the antepartum hemorrhage? If yes, please provide a copy of the operation report/ notes.	Yes	No
47. Was the patient admitted to hospital within 42 days after childbirth? If yes, please state the period of confinement _____ to _____ (DD/MM/YYYY) (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 48 to 50 if the patient's condition is on: Placenta Increta/ Percreta		
48. Was there abnormal adherent of the placenta to the myometrium.	Yes	No
49. Was there presence of severe hemorrhage?	Yes	No
50. Was a surgical removal of placenta done? If yes, please state the date of surgery. _____(DD/MM/YYYY) Please also provide a copy of the histology report and operation report.	Yes	No
Please complete Question 51 to 54 if the patient's condition is on: Uterine Rupture		
51. Was there rupture of uterus during pregnancy or childbirth?	Yes	No
52. If yes, did the rupture result in foetal death or hysterectomy?	Yes	No
53. Was hysterectomy performed as a result of the uterine rupture? If yes, please provide a copy of the operation report/ notes.	Yes	No
54. Was the patient admitted to hospital within 42 days after childbirth? If yes, please state the period of confinement _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
Please complete Question 55 to 57 if the patient's condition is on: HELLP Syndrome		
55. Please advise if the following were present: a) Haemolysis ☐ Yes ☐ No b) Elevated Liver Enzymes ☐ Yes ☐ No c) Low Platelets ☐ Yes ☐ No		

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

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

56. Did the pregnancy complication result in foetal death? If yes, when did the death of foetus occur? _____ (DD/MM/YYYY)	Yes	No
57. Was the patient admitted to hospital within 42 days after childbirth? If yes, please state the period of confinement _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
Please complete Question 58 to 71 if the patient's condition is on: **Gestational diabetes mellitus**		
58. Does the patient have gestational diabetes mellitus (GDM)? If yes, a) please state the date of diagnosis _____ (DD/MM/YYYY) b) how many weeks pregnant was the patient when she developed GDM _____	Yes	No

59. Did the patient's GDM screening results meet any of the following values:

a) Fasting plasma glucose 5.1 – 6.9 mmol/L	☐ Yes	☐ No
b) 1-hr plasma glucose ≥ 10.0 mmol/L following a 75g oral glucose load	☐ Yes	☐ No
c) 2-hr plasma glucose 8.5 – 11.0 mmol/L following a 75g oral glucose load	☐ Yes	☐ No

Please provide copies of the GDM screening results.

60. Did the patient give birth to a baby with foetal macrosomia? Please state the birth weight of the baby _____	Yes	No
61. Did the baby have neonatal hypoglycaemia?	Yes	No
62. Was the plasma glucose level less than 1.65 mmol/L (30 mg/dL) in the first 24 hours of life? Please state the plasma glucose level _____	Yes	No

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

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

63. Did the GDM persist after delivery?	Yes	No

64. When was the patient confirmed to have progressed to permanent diabetes?

_____ (DD/MM/YYYY)

65. Was the permanent diabetes a Type 1 or Type 2 diabetes?

Type 1 / Type 2 (please circle the appropriate)

66. Did the patient have any of the following:

a) Symptoms of diabetes mellitus	☐ Yes	☐ No
b) Random plasma glucose concentration of at least 200 mg/dL (11.1 mmol/L)	☐ Yes	☐ No
c) Fasting plasma glucose level of at least 8 hrs of 126 mg/dL (7.0 mmol/L) or higher?	☐ Yes	☐ No
d) Two-hour plasma glucose level of 200 mg/dL or more during an oral glucose	☐ Yes	☐ No
e) HbA1c above 6.5%	☐ Yes	☐ No

67. Were the above values tested at least twice? Please provide a copy of the laboratory reports	Yes	No
68. Does the patient have any prior history of GDM, diabetes mellitus or impaired glucose tolerance prior to this pregnancy?	Yes	No

69. If yes, please state the date of diagnosis and name and address of doctor who made the diagnosis.

a) Date of diagnosis: _____ (DD/MM/YYYY)

b) Diagnosis made: _____

c) Name and address of doctor who made the diagnosis: _____

_____

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

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

70. Did the patient develop any pregnancy complication during her pregnancy? If yes, please specify the complication: _____	Yes	No
71. Please state the date of diagnosis of the pregnancy complication. Date of diagnosis: _____ (DD/MM/YYYY)		
Please complete Question 72 to 74 if the patient's condition is on: Still Birth		
72. Was there death of the baby after 28 weeks gestation? If yes, please state the cause of death of the baby: _____	Yes	No
73. Was the baby electively terminated or aborted? If yes, was the termination required due to medical reasons? Please specify the reason for termination: _____	Yes	No
74. Was the baby alive at the time of delivery?	Yes	No
Please complete Question 75 to 76 if the patient's condition is on: Psychiatrist/ Psychologist consultation		
75. Did the patient receive any psychological or psychiatric consultation during her pregnancy or post-delivery? If yes, please state the period which she received psychological or psychiatric consultation. _____ to _____ (DD/MM/YYYY) (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:

76. Why did the patient require psychological or psychiatric consultation?

Please provide:

- The diagnosis: _____ ; and
- Date of diagnosis: _____ (DD/MM/YYYY)

Please complete Question 77 to 78 if the patient's condition is on:
Post-partum depression

77. Did the patient suffer from postpartum depression?	Yes	No

78. When was the patient diagnosed to have postpartum depression?

Date of diagnosis: _____ (DD/MM/YYYY)

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. 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

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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