PRUHospital Care360 **CLAIM FORM**
(To be completed by Policyholder/Proper Claimant)

1. The Company does not admit liability by the mere issuance of this form.

2. Please complete and return this form together with the medical report, finalised inpatient/day surgery bills and copy of detailed inpatient/day surgery bill to the Company.

3. All documents submitted that are not in English must be translated to English by an accredited translator at your own or the claimant's expense.

4. You must file your claims within 180 days from the date of discharge from the hospital.

Personal Particulars

Important Note: Please note that, under the policy terms and condition, the policy may be void if any information provided in this claim form is materially false or misleading.

We reserve the right to ask you or your legal representative to provide, at your own expense, more documents or evidence to our satisfaction to help us assess your claim. The expenses for completion of the medical report or any other documents will be borne by you.

Name of Policyholder/Proper Claimant	NRIC Number	Policy Number	Contact Number

Please leave this blank if Policyholder is the same as Life Assured

Name of Life Assured	NRIC Number	Policy Number	Contact Number

Details of Claim (Please tick the relevant boxes)

Benefit Plan Type

☐ Plan 1 ☐ Plan 2 ☐ Plan 3

Details of Illness / Injury

1. What is the cause of hospitalisation?

☐ Illness

☐ Accident

2. Was there a police report? Yes ☐ No ☐
(If Yes, please provide a copy.)

3. Describe in detail the nature of the illness / injury. If the condition is caused by an accident, please specify how the incident occurred, where it took place and when it happened.

Please tick the benefits you are claiming and complete the details accordingly.

☐ **Daily Hospital Income Benefit**

Date of hospitalisation (ddmmyyyy): From _____ to _____

Have you suffered this or a similar condition or a recurrence of a previous illness or injury?

☐ Yes ☐ No If Yes, please specify _____

Date of first consultation of the injury/illness _____

Date in which you first noticed symptoms of condition _____

☐ **Daily Intensive Care Unit Benefit**

Number of days for ICU stays: _____

☐ **Day Surgery Benefit**

Name of Surgical Procedure _____

Name of Surgeon _____

☐ **Daily Accidental Hospital Income Benefit**

Date (ddmmyyyy) and Time of Accident _____

☐ **Daily Infectious Disease Hospital Income Benefit**

☐ **Homecare Benefit**

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

DECLARATION

1. I hereby declare that the information that is disclosed on this form is to the best of my knowledge and belief, true, complete and accurate, and that no material information has been withheld or is any relevant circumstances omitted. I agree that if I have provided any false or fraudulent information, or suppress, conceal and/or falsely state any material facts with regard to this claim, the policy shall be void and all rights of recovery in respect of past or future claims shall be forfeited.

2. I acknowledge and accept that Prudential Assurance Company Singapore (Pte) Limited ("**PACS**") shall be at liberty to deny liability or recover amounts paid, whether wholly or partially, if any of the information disclosed on this form is incomplete, untrue or incorrect in any respect, or if the policy does not provide cover on which such claim is made.
3. I understand and agree that the submission of this form does not mean that my request will be processed, and that any payout under the policy shall be in PACS sole and absolute discretion. I further acknowledge and agree that the furnishing of this form or other supplemental forms by PACS is neither an admission that there was any insurance in force on the life in question, nor an admission of liability nor a waiver of any of its rights or defences.
4. I hereby warrant and represent that I have been duly authorised to submit this claim and all information submitted in connection with the claim and policy.
5. I acknowledge and accept that PACS expressly reserves its rights to require or obtain further information and documentation as it deems necessary. I acknowledge that I am solely responsible for the costs of providing such information and documentation as requested by PACS.
6. I 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 document(s) that were submitted for reimbursement to PACS for verification as it deems necessary.
8. For the purposes of (i) assessing, processing and investigating my claim arising under this form and such other purposes ancillary or related to the assessing, processing and investigating my claim(s), (ii) customer servicing, statistical analysis, conducting customer due diligence, reporting to regulatory or supervisory authorities, auditing and recovery of any debts owing to PACS under the policy, (iii) storage and retention, (iv) meeting requirements of prevailing internal policies of PACS, and (v) 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)**") pertaining to this claim, to disclose, release, transfer and exchange any information to 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, all 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 any Person(s)/Organisation(s) listed above, 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 assisting with my claim 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, I represent and warrant that I have obtained the consent of the Individual for PACS, its officers, employees, representatives or distribution partners 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's Privacy Notice. 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 General Data Protection Regulation ("**GDPR**") Privacy Notice (which is available at https://www.prudential.com.sg/GDPR-Notice) for more information on the rights available to me under the GDPR.
10. 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 by me herein.
11. I agree to receive communication on the claim by email, SMS and/or hard copies by post.
12. I agree that (i) Prudential shall have full access to the information stated in this form, and (ii) this authorisation and declaration shall form part of my proposed application for the relevant insurance benefits, and a photocopy of this form shall be treated as valid and binding as if it were the original.

Date & Signature of Life Assured above age 18 years

Date & Signature of Policyowner

Relationship to Life Assured