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

Female Illnesses		Medical Procedure due to Malignant Condition		Support benefit	
Malignant Cancer/ Choriocarcinoma		Radical vulvectomy		Oocyte Cryopreservation due to covered female cancers	
Carcinoma in situ of breast/ cervix uteri		Wertheim's operation		Molecular Gene Expression Profiling test for breast cancer	
Reconstructive Surgery		Total pelvic exenteration		Hormone Replacement Therapy due to Cancer	
Breast reconstructive surgery following a mastectomy		Hysterectomy		Outpatient Psychiatric benefit due to female cancer	
Skin grafting due to skin cancer		Mastectomy			
		Bilateral/ unilateral breast lumpectomy			

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

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. If the patient was referred to you for further management, please provide the name and practice address of the referral doctor.							
10. Please provide the name and address of the patient's regular attending doctor.							

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

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

SECTION 2		
Please complete Question 1 to 8 if patient's condition is on: **Malignant Cancer/ Choriocarcinoma** **Carcinoma-in-situ of breast/ cervix uteri** **Medical Procedure due to a malignant condition** **Reconstructive surgery following a mastectomy** **Skin grafting due to skin cancer**		
1. Please state the origin of the malignant tumor.		
2. What is the staging of the tumor? Please indicate the TNM staging or its equivalent.		
3. Were regional lymph nodes involved?	Yes	No
4. Is this an invasive cancer based on the histology report? (please attach a copy of the histology report)	Yes	No
5. Is the tumor histologically described as pre-malignant or non-invasive, including but not limited to Carcinoma-in-situ, Cervical Dysplasia, CIN-I, CIN-II, HSIL or LSIL?	Yes	No
6. Has the tumor been surgically excised?	Yes	No
a. Please state the nature of the surgery performed and date of the surgery (please attach a copy of the operation report).		
7. Please confirm if the surgery that was done was due to a diagnosis of invasive cancer.	Yes	No
8. Did the patient undergo any reconstructive surgery or skin grafting due to cancer?	Yes	No
a. If yes, please state the nature of the operation and when it was performed (please attach a copy of the operation report).		

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

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

Please complete Question 9 to 11 if patient's condition is on: Oocyte Cryopreservation		
9. Has the insured been prescribed to undergo chemotherapy or radiotherapy?	Yes	No
10. Has the patient been recommended for cryopreservation?	Yes	No
11 a. Has the patient utilized the services for cryopreservation of mature oocytes (eggs) or embryos?	Yes	No
b. If yes, please provide the date of cryopreservation	(DD/MM/YYYY)	
c. Was this cryopreservation utilized before chemotherapy or radiotherapy from a registered cryopreservation centre?	Yes	No
Please complete Question 12 to 13 if patient's condition is on: Molecular Gene Expression Profiling test for Breast cancer		
12. Was an immunohistochemistry testing done to confirm the breast tumor as estrogen receptor positive?	Yes	No
Please provide a copy of the immunohistochemistry report and/ or hormone receptor assay.		
13. Have you recommended Molecular Gene Expression Profiling Test?	Yes	No
Please complete Question 14 to 19 if the patient's condition is on: Hormone replacement therapy after oophorectomy and/ or hysterectomy		
14. Has the patient undergone oophorectomy and/ or hysterectomy?	Yes	No
15. Please state the nature of the operation and when it was performed Please also provide a copy of the operation notes/ reports.		
16. Is the oophorectomy and/ hysterectomy bilateral?	Yes	No
17. Is the procedure performed due to Cancer?	Yes	No
18. Was hormone replacement therapy (HRT) advised after the surgery?	Yes	No
19. Please describe the symptoms that have necessitated the HRT.		

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 the patient's condition is on: Psychiatric condition due to traumatic life event – Cancer		
20. Was the patient diagnosed with Major Depressive Disorder (MDD? And/ or Anxiety Disorders?	Yes	No
21. Was the patient's Major Depressive Disorder (MDD) and/ or Anxiety Disorder caused by Cancer?	Yes	No
22. If yes, please specify the site of cancer.		
23. What was the treatment prescribed for MDD and/ or Anxiety Disorder?		
24. Was the patient under medication for at least 6 continuous months?	Yes	No
SECTION 3		
1. Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?	Yes	
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:

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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