

## HOSPITAL CARE BENEFIT CLAIM FORM (PRUSMART LADY, PRULADY, PRUFIRST GIFT, PRUFIRST PROMISE)

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 circle and tick the appropriate box for the Hospital Care benefit you are claiming.

HOSPITAL CARE (CHILD)		HOSPITAL CARE (MOTHER)	
Hospitalisation of child due to: <ul style="list-style-type: none"> <li>- Incubation of newborn child for more than 3 consecutive days immediately following birth</li> <li>- Premature birth requiring neonatal ICU</li> <li>- Bronchitis</li> <li>- Dengue hemorrhagic fever</li> <li>- Phototherapy for severe neonatal jaundice</li> <li>- Pneumonia</li> <li>- Severe measles</li> <li>- Severe Hand, Foot and Mouth Disease (HFMD)</li> <li>- Chikungunya fever</li> <li>- Typhoid fever</li> <li>- Rabies</li> <li>- Zika</li> <li>- MERS-CoV</li> <li>- Ebola</li> <li>- SARS</li> <li>- Influenza A – Avian Influenza (H7N9 and A(H5N1)</li> <li>- Nipah virus encephalitis</li> <li>- Japanese encephalitis</li> <li>- Creutzfeldt-Jakob disease</li> <li>- Malaria</li> </ul>		Hospitalisation of life assured (mother) due to: <ul style="list-style-type: none"> <li>- Zika</li> <li>- Inpatient Psychiatric Treatment</li> <li>- Post-natal anaemia</li> <li>- Puerperal Pyrexia</li> <li>- Pulmonary Embolism</li> <li>- Repair of 4th degree perineal tear</li> <li>- Septic pelvic thrombophlebitis</li> <li>- Surgical Site infection following caesarian section</li> <li>- Uterine infection or transfusion due to retained placenta following childbirth</li> <li>- Complications of Lactational Mastitis</li> </ul>	
		Hospital care accelerator	

C170621

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
<b>5. OTHER INSURANCE</b>			
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 2 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			
<b>SECTION I</b>			
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 <b>Part II</b>	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 II**

**Please complete Question 1 if patient's condition is on:  
Incubation of a newborn child for more than 3 consecutive days immediately following birth**

1. Was the child incubated for more than 3 consecutive days immediately following birth?

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 2 to 3 if the patient's condition is on:  
Premature birth requiring neonatal ICU**

2. Was the child born prematurely?  
If yes, please provide the following information:

i) gestation period \_\_\_\_\_ weeks

ii) birth weight \_\_\_\_\_ grams

Yes

No

3. Was the child admitted to a neonatal intensive care unit (NICU) or High Dependency Unit (HDU)?  
If yes, please state the period of confinement

\_\_\_\_\_ to \_\_\_\_\_  
(DD/MM/YYYY) (DD/MM/YYYY)

Yes

No

**Please complete Question 4 if the patient's condition is on:  
Hospitalisation of life assured's child due to Bronchitis**

4. Was the child admitted for bronchitis?  
Please state the period of confinement (including ICU and HDU ward, if any):

\_\_\_\_\_ to \_\_\_\_\_  
(DD/MM/YYYY) (DD/MM/YYYY)

Period in ICU: \_\_\_\_\_ to \_\_\_\_\_  
(DD/MM/YYYY) (DD/MM/YYYY)

Period in HDU: \_\_\_\_\_ to \_\_\_\_\_  
(DD/MM/YYYY) (DD/MM/YYYY)

Yes

No

**Please complete Question 5 to 7 if the patient's condition is on:  
Hospitalisation of life assured's child due to Dengue Hemorrhagic Fever**

5. Was the child admitted for dengue hemorrhagic fever?  
Please state the period of confinement (including ICU and HDU ward, if any):

\_\_\_\_\_ to \_\_\_\_\_  
(DD/MM/YYYY) (DD/MM/YYYY)

Period in ICU: \_\_\_\_\_ to \_\_\_\_\_  
(DD/MM/YYYY) (DD/MM/YYYY)

Period in HDU: \_\_\_\_\_ 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:

6. What is the grade of the patient's Dengue Hemorrhagic Fever based on WHO classification? Grade 1/ 2/ 3/ 4 (please circle)		
7. Were any of the following findings present?		
- History of continuous high fever (for 2 or more days)	Yes	No
- Minor or major hemorrhagic manifestations	Yes	No
- Thrombocytopenia (less than or equal to 100000 per mm <sup>3</sup> )	Yes	No
- Haemoconcentration (haematocrit increased by 20% or more)	Yes	No
- Evidence of plasma leakage (i.e. pleural effusion, ascites or hypoproteinaemia etc)	Yes	No
- Evidence of the Dengue Shock Syndrome (DSS) confirmed by a consultant physician	Yes	No
- hypotension (< 80 mmHg) or narrow pulse pressure ( $\leq$ 20 mmHg)	Yes	No
- evidence of tissue hypoperfusion such as cold, clammy skin, oliguria or a metabolic acidosis	Yes	No
<b>Please complete Question 8 to 11 if the patient's condition is on: Hospitalisation of life assured's child due to Phototherapy for severe neonatal jaundice</b>		
8. Did the child received phototherapy treatment for neonatal jaundice?	Yes	No
9. Was the phototherapy received on an inpatient basis?	Yes	No
10. Please state the period when the newborn received inpatient phototherapy:  _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)		
11. Was the total serum bilirubin level > 250 $\mu$ mol/L Please state the reading and provide us with a copy of the laboratory result  _____	Yes	No

Signature & Practice Stamp of the Medical Specialist who filled up <b>Part II</b>	Date
---	------



Name of Patient:

NRIC / Passport No. of Patient:

**Please complete Question 12 if the patient's condition is on:  
Hospitalisation of life assured's child due to Pneumonia**

<p>12. Was the child admitted for pneumonia? Please state the period of confinement (including ICU and HDU ward, if any):</p> <p>_____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)</p> <p>Period in ICU: _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)</p> <p>Period in HDU: _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)</p>	<p>Yes</p>	<p>No</p>
---	------------	-----------

**Please complete Question 13 to 15 if the patient's condition is on:  
Hospitalisation of life assured's child due to Severe measles**

<p>13. Was the patient admitted for measles?</p>	<p>Yes</p>	<p>No</p>
<p>14. Please state the period of admission:</p> <p>_____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)</p>		
<p>15. Did the condition result in any of the following complications:</p>		
<p>- Pneumonia</p>	<p>Yes</p>	<p>No</p>
<p>- Encephalitis</p>	<p>Yes</p>	<p>No</p>
<p>- Convulsions</p>	<p>Yes</p>	<p>No</p>
<p>- Hepatitis</p>	<p>Yes</p>	<p>No</p>

**Please complete Question 16 to 18 if the patient's condition is on:  
Hospitalisation of life assured's child due to Severe Hand, Foot and Mouth Disease (HFMD)**

<p>16. Was the patient admitted for Hand, Foot and Mouth Disease? If yes, please state the period of admission</p> <p>_____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)</p>	<p>Yes</p>	<p>No</p>
--	------------	-----------

<p>Signature &amp; Practice Stamp of the Medical Specialist who filled up <b>Part II</b></p>	<p>Date</p>
--	-------------

Name of Patient:

NRIC / Passport No. of Patient:

17. Please provide us a copy of the laboratory report showing positive isolation of the causative virus.		
18. Was the Hand, Foot and Mouth Disease associated with any of the following complications:		
- Encephalitis	Yes	No
- Myocarditis	Yes	No
<b>Please complete Question 19 to 21 if the patient's condition is on: Hospitalisation of life assured's child due to Chikungunya fever</b>		
19. Was the patient admitted for Chikungunya fever?  If yes, please state the period of admission  _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
20. Please provide us a copy of the laboratory report showing positive isolation of the causative virus.		
21. Was the condition associated with any of the following complications:		
- Myocarditis	Yes	No
- Ocular disease (uveitis, retinitis)	Yes	No
- Hepatitis	Yes	No
- Severe bullous lesions	Yes	No
- Neurological disease such as meningoencephalitis, Guillain-Barre syndrome, myelitis or cranial nerve palsies	Yes	No
<b>Please complete Question 22 to 24 if the patient's condition is on: Hospitalisation of life assured's child due to Typhoid fever</b>		
22. Was the patient admitted for typhoid fever?  If yes, please state the period of admission  _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No

Signature & Practice Stamp of the Medical Specialist who filled up <b>Part II</b>	Date
---	------

Name of Patient:

NRIC / Passport No. of Patient:

23. Was the diagnosis confirmed on:		
- Positive culture of Salmonella typhi from blood (by the Widal test (titer $\geq$ 1/320) and/ or the Tubex test (+4))	Yes	No
- Stool sample	Yes	No
Please provide us a copy of the laboratory report.		
24. Was the condition associated with any of the following complications:		
- Intestinal bleeding	Yes	No
- Intestinal perforation	Yes	No
- Severe neuropsychiatric symptoms namely delirium or psychosis	Yes	No
<b>Please complete Question 25 to 27 if the patient's condition is on: Hospitalisation of life assured's child due to Rabies</b>		
25. Was the patient admitted for rabies?  If yes, please state the period of admission  _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
26. Did the patient present with any of the following symptoms:		
- Muscle fasciculations	Yes	No
- Delirium	Yes	No
- Psychosis	Yes	No
- Seizures	Yes	No
- Aphasia	Yes	No
27. Did the patient receive prophylactic post exposure vaccination?	Yes	No

Signature & Practice Stamp of the Medical Specialist who filled up <b>Part II</b>	Date
---	------

Name of Patient:

NRIC / Passport No. of Patient:

**Please complete Question 28 to 30 if patient's condition is on:  
Hospitalisation of life assured's child due to Zika**

28. Was the child admitted to hospital as a result of Zika?

Yes

No

If yes, please state the period of confinement

\_\_\_\_\_ to \_\_\_\_\_  
(DD/MM/YYYY) (DD/MM/YYYY)

29. Was the diagnosis of Zika virus infection confirmed on positive isolation of the virus?

Yes

No

30. Was the hospitalization due to complications of Zika (eg. microcephaly)?

Yes

No

If yes, please provide details.

**Please complete Question 31 to 33 if the patient's condition is on:  
Hospitalisation of life assured's child due to MERS-CoV**

31. Was the patient admitted for MERS-CoV?

Yes

No

If yes, please state the period of admission

\_\_\_\_\_ to \_\_\_\_\_  
(DD/MM/YYYY) (DD/MM/YYYY)

32. Was the diagnosis of MERS-CoV detected via reverse-transcription polymerase chain reaction (RT-PCR) assay?

Yes

No

33. Were there confirmation from:

- At least two specific genomic targets?

Yes

No

- A single positive target with sequencing of a second target

Yes

No

Signature & Practice Stamp of the Medical Specialist who filled up <b>Part II</b>	Date
---	------

Name of Patient:

NRIC / Passport No. of Patient:

**Please complete Question 34 to 35 if the patient's condition is on:  
Hospitalisation of life assured's child due to Ebola**

<p>34. Was the patient admitted for Ebola?</p> <p>If yes, please state the period of admission</p> <p>_____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)</p>	<p>Yes</p>	<p>No</p>
--	------------	-----------

<p>35. Was the diagnosis of Ebola confirmed on positive isolation of the virus?</p>	<p>Yes</p>	<p>No</p>
---	------------	-----------

**Please complete Question 36 to 39 if the patient's condition is on:  
Hospitalisation of life assured's child due to SARS**

<p>36. Was the patient admitted for SARS?</p> <p>If yes, please state the period of admission</p> <p>_____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)</p>	<p>Yes</p>	<p>No</p>
---	------------	-----------

<p>37. Was the diagnosis of SARS confirmed on positive isolation in cell culture of SARS-CoV from a clinical specimen?</p>	<p>Yes</p>	<p>No</p>
--	------------	-----------

<p>38. Was the diagnosis of SARS detected via reverse-transcription polymerase chain reaction (RT-PCR) assay?</p>	<p>Yes</p>	<p>No</p>
---	------------	-----------

<p>39. Were there confirmation from:</p>		
--	--	--

<p>- At least two clinical specimens from different sources?</p>	<p>Yes</p>	<p>No</p>
--	------------	-----------

<p>- At least two clinical specimens collected from the same source on 2 different days?</p>	<p>Yes</p>	<p>No</p>
--	------------	-----------

**Please complete Question 40 to 41 if the patient's condition is on:  
Hospitalisation of life assured's child due to Influenza A – Avian Influenza (H7N9 and A(H5N1))**

<p>40. Was the patient admitted for Avian Influenza?</p> <p>If yes, please state the period of admission</p> <p>_____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)</p>	<p>Yes</p>	<p>No</p>
--	------------	-----------

<p>Signature &amp; Practice Stamp of the Medical Specialist who filled up <b>Part II</b></p>	<p>Date</p>
--	-------------

Name of Patient:

NRIC / Passport No. of Patient:

41. Was the diagnosis of Avian Influenza confirmed on positive isolation of the virus?	Yes	No
<b>Please complete Question 42 to 43 if the patient's condition is on: Hospitalisation of life assured's child due to Nipah virus encephalitis</b>		
42. Was the patient admitted for Nipah virus encephalitis?  If yes, please state the period of admission  _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
43. Was the diagnosis of Nipah virus encephalitis confirmed on positive isolation of the virus via reverse transcriptase polymerase chain reaction (RT-PCR)?	Yes	No
<b>Please complete Question 44 to 45 if the patient's condition is on: Hospitalisation of life assured's child due to Japanese encephalitis</b>		
44. Was the patient admitted for Japanese encephalitis?  If yes, please state the period of admission  _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
45. Was the diagnosis of Japanese encephalitis confirmed on positive culture from cerebrospinal fluid?	Yes	No
<b>Please complete Question 46 to 48 if the patient's condition is on: Hospitalisation of life assured's child due to Creutzfeldt-Jakob disease</b>		
46. Was the patient admitted for Creutzfeldt-Jakob disease?  If yes, please state the period of admission  _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
47. Was the condition accompanied by any of the following signs and symptoms:		
- Uncontrolled muscular spasm or tremor	Yes	No
- Severe progressive dementia	Yes	No

Signature & Practice Stamp of the Medical Specialist who filled up <b>Part II</b>	Date
---	------

Name of Patient:

NRIC / Passport No. of Patient:

- Cerebellar dysfunction	Yes	No
- Athetosis	Yes	No
48. Was the diagnosis confirmed on the following? Please provide copy of the laboratory reports.		
- Electroencephalography (EEG)	Yes	No
- Cerebrospinal fluid (CSF) findings	Yes	No
- Computed Tomography (CT) scan	Yes	No
- Magnetic Resonance Imaging (MRI)	Yes	No
<b>Please complete Question 49 to 50 if the patient's condition is on: Hospitalisation of life assured's child due to Malaria</b>		
49. Was the patient admitted for Malaria?  If yes, please state the period of admission  _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
50. Was the diagnosis confirmed with light microscopy with a parasitaemia of $\geq 100,000$ parasites/ mL of blood?	Yes	No
<b>Please complete Question 51 if the patient's condition is on: Hospitalisation of life assured (mother) due to Zika</b>		
51. Was the life assured (mother) admitted to hospital as a result of Zika during the term of her pregnancy?  If yes, please state the period of confinement  _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
<b>Please complete Question 52 to 57 if patient's condition is on: Hospitalisation of life assured (mother) due to Inpatient Psychiatric Treatment</b>		
52. Was the patient admitted to hospital for peripartum psychosis?	Yes	No

Signature & Practice Stamp of the Medical Specialist who filled up <b>Part II</b>	Date
---	------

Name of Patient:

NRIC / Passport No. of Patient:

53. Please state the period of admission.

\_\_\_\_\_ to \_\_\_\_\_  
(DD/MM/YYYY) (DD/MM/YYYY)

54. If no, please state the cause of admission and when was it diagnosed?

\_\_\_\_\_

55. Was the diagnosis made based on DSM-5 criteria?

Yes

No

56. Was the diagnosis confirmed by a psychiatrist?

Yes

No

57. Please state the period of admission.

\_\_\_\_\_ to \_\_\_\_\_  
(DD/MM/YYYY) (DD/MM/YYYY)

**Please complete Question 58 to 61 if patient's condition is on:  
Hospitalisation of life assured (mother) due to Post-natal anaemia**

58. Was the patient admitted to hospital for treatment of postpartum anaemia?

Yes

No

59. Please state the period of admission.

\_\_\_\_\_ to \_\_\_\_\_  
(DD/MM/YYYY) (DD/MM/YYYY)

60. Did the patient receive blood transfusion during the admission?

Yes

No

61. Was the patient's Hb level prior to transfusion <70 g/l?

Yes

No

What was the patient's Hb level prior to transfusion? Please provide copy of the laboratory report.

\_\_\_\_\_

**Please complete Question 62 to 64 if patient's condition is on:  
Hospitalisation of life assured (mother) due to Puerperal Pyrexia**

62. Was the patient admitted to the Intensive care unit for treatment of infection, causing puerperal pyrexia?

Yes

No

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

Date



Name of Patient:

NRIC / Passport No. of Patient:

63. Please state the period of admission.

\_\_\_\_\_ to \_\_\_\_\_  
(DD/MM/YYYY) (DD/MM/YYYY)

64. Did the patient present with any of the following symptoms:

- High fever;	Yes	No
- Abdominal pain;	Yes	No
- Hypotension; and	Yes	No
- Shock	Yes	No

**Please complete Question 65 to 68 if patient's condition is on:  
Hospitalisation of life assured (mother) due to Pulmonary Embolism**

65. Was the patient admitted to hospital for peripartum psychosis?

Yes No

66. Please state the period of admission.

\_\_\_\_\_ to \_\_\_\_\_  
(DD/MM/YYYY) (DD/MM/YYYY)

67. Did the patient present with any of the following symptoms:

- Chest pain;	Yes	No
- Difficulty in breathing; and	Yes	No
- Low arterial oxygen level;	Yes	No

68. Were any of the following tests done to confirm the diagnosis?

- D-dimer test;	Yes	No
- CT pulmonary angiography	Yes	No

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

Date

Name of Patient:

NRIC / Passport No. of Patient:

- Ventilation perfusion scan	Yes	No
Please provide us with a copy of the laboratory reports.		
<b>Please complete Question 69 to 71 if patient's condition is on: Hospitalisation of life assured (mother) due to Repair of 4th degree perineal tear</b>		
69. Did the patient sustain a fourth-degree perineal tear during childbirth?	Yes	No
70. Was surgery done to repair the tear?	Yes	No
71. Please state the date the surgical repair was done.  _____ (DD/MM/YYYY)		
<b>Please complete Question 72 to 75 if patient's condition is on: Hospitalisation of life assured (mother) due to Septic pelvic thrombophlebitis</b>		
72. Did the patient suffer from phlebitis due to infected blood clot?	Yes	No
73. Was the diagnosis supported by ultrasound, CT scan or MRI?  Please provide us with a copy of the scan report.	Yes	No
74. Did the patient receive inpatient treatment with antibiotics and anticoagulation?	Yes	No
75. Please state the period of admission.  _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)		
<b>Please complete Question 76 to 78 if patient's condition is on: Hospitalisation of life assured (mother) due to Surgical Site infection following caesarian section</b>		
76. Did the patient suffer from infection of caesarean section surgical site following childbirth?	Yes	No
77. Did she receive inpatient treatment with incision and drainage at the surgical site and intravenous antibiotics?	Yes	No

Signature & Practice Stamp of the Medical Specialist who filled up <b>Part II</b>	Date
---	------

Name of Patient:

NRIC / Passport No. of Patient:

78. Please state the period of admission due to the infection.

\_\_\_\_\_ to \_\_\_\_\_  
 (DD/MM/YYYY) (DD/MM/YYYY)

**Please complete Question 79 to 84 if patient's condition is on:  
 Hospitalisation of life assured (mother) due to Uterine infection or transfusion due to retained placenta following childbirth**

79. Did the patient suffered from complications of retained placenta after a term vaginal delivery?

Yes

No

80. Did she receive inpatient treatment with intravenous antibiotics or a transfusion for excessive blood loss?

Yes

No

81. Please state the period of admission.

\_\_\_\_\_ to \_\_\_\_\_  
 (DD/MM/YYYY) (DD/MM/YYYY)

82. Has the patient undergone surgical removal of the retained placenta?

Yes

No

83. Please state the date of surgical removal \_\_\_\_\_(DD/MM/YYYY)

84. Did the patient received surgery or other treatment for incomplete uterine evacuation following miscarriage or termination of pregnancy during the admission? Please provide details of the surgery, surgery date or treatment:

Yes

No

**Please complete Question 85 to 88 if patient's condition is on:  
 Hospitalisation of life assured (mother) due to Complications of Lactational Mastitis**

85. Did the patient suffer from lactational mastitis?

Yes

No

86. Did she receive inpatient treatment?

Yes

No

87. What was the treatment received?

- Incision and drainage surgery

Yes

No

- Simple needle aspiration

Yes

No

- Others: please specify \_\_\_\_\_

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

Date

Name of Patient:

NRIC / Passport No. of Patient:

88. Please state the period of admission.

\_\_\_\_\_ to \_\_\_\_\_  
(DD/MM/YYYY) (DD/MM/YYYY)

**Please complete Question 89 to 93 for Hospital care accelerator**

89. Was the patient admitted to hospital during her pregnancy or post-delivery?

Yes

No

90. What was the gestation period when the patient was admitted?

Yes

No

91. Please state the period of admission.

\_\_\_\_\_ to \_\_\_\_\_  
(DD/MM/YYYY) (DD/MM/YYYY)

92. Was the patient admitted to the ICU ward?

Yes

No

93. Please state the period of admission in the ICU ward (if any).

\_\_\_\_\_ to \_\_\_\_\_  
(DD/MM/YYYY) (DD/MM/YYYY)

**SECTION III**

1. Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?  
If yes, please provide the date of HIV/ AIDS diagnosis.

Yes

No

\_\_\_\_\_ (DD/MM/YYYY)

2. Is the diagnosis related to the consumption of any intoxicating liquor, drugs or poison, suicide or attempted suicide or intentional self-injury?

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:

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.		
4. Was this pregnancy conceived through any fertility treatment? (please tick as applicable)  a) In-vitro fertilization (IVF) <input type="checkbox"/> b) Intracytoplasmic sperm injection (ICSI) <input type="checkbox"/> c) Intrauterine insemination (IUI) <input type="checkbox"/> d) Intracervical insemination (ICI) <input type="checkbox"/> e) Others: <input type="checkbox"/>  Please specify _____  If yes, please state the number of foetus conceived: _____	Yes	No
5. Was the child conceived through a pregnancy, which carried 3 or more babies in a single pregnancy?	Yes	No
<b>SECTION IV</b>		
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?		
Name and Signature of the Medical Specialist who filled up <b>Section 2</b>	Date	
Practice Stamp of the Medical Specialist		

## **PART 3 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.

Prudential Assurance Company Singapore (Pte) Limited  
Postal Address: Robinson Road P.O. Box 492 Singapore 900942  
Telephone: 6535 8988 Fax: 6734 9555  
Part of Prudential Corporation plc Reg. No 199002477Z