PRUDENTIAL

PruCustomer Line: 1800 -333 0 3333

SEVERE INFECTIONS PROTECT CLAIM FORM

(Serious Infectious Diseases)

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 Severe Infections Protect benefit you are claiming.

SEVERE INFECTIONS PROTECT

- Avian Influenza
- Nipah Virus Infection
- Plague
- Poliomyelitis
- Rabies
- Yellow Fever
- Botulism
- Dengue Fever
- Dengue Haemorrhagic Fever
- Diphtheria
- Japanese Encephalitis
- Malaria
- Measles
- Rubella
- Zika Virus Infection
- Cholera
- Haemophilus Influenzae Type b Disease
- Leptospirosis
- Meningococcal Disease
- Murine Typhus
- Paratyphoid
- Typhoid Fever
- Tetanus
- Tuberculosis
- Campylobacteriosis
- Hepatitis A, acute
- Hepatitis B, acute
- Hepatitis C, acute
- Hepatitis E, acute
- Legionellosis
- Leprosy
- Melioidosis
- Pertussis
- Pneumococcal Disease (Invasive)
- Salmonellosis (non-typhoidal)

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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 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			

SECTION I

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.						
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.						

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

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

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

1. What was the serious infectious disease diagnosed? (Please circle accordingly and to provide the supporting diagnosis report confirming the diagnosis)

- Avian Influenza	Yes	No
- Nipah Virus Infection	Yes	No
- Plague	Yes	No
- Poliomyelitis	Yes	No
- Rabies	Yes	No
- Yellow Fever	Yes	No
- Botulism	Yes	No
- Dengue Fever	Yes	No
- Dengue Haemorrhagic Fever	Yes	No
- Diphtheria	Yes	No
- Japanese Encephalitis	Yes	No
- Malaria	Yes	No
- Measles	Yes	No
- Rubella	Yes	No
- Zika Virus Infection	Yes	No
- Cholera	Yes	No
- Haemophilus Influenzae Type b Disease	Yes	No

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

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

- Leptospirosis	Yes	No
- Meningococcal Disease	Yes	No
- Murine Typhus	Yes	No
- Paratyphoid	Yes	No
- Typhoid Fever	Yes	No
- Tetanus	Yes	No
- Tuberculosis	Yes	No
- Campylobacteriosis	Yes	No
- Hepatitis A, acute	Yes	No
- Hepatitis B, acute	Yes	No
- Hepatitis C, acute	Yes	No
- Hepatitis E, acute	Yes	No
- Legionellosis	Yes	No
- Leprosy	Yes	No
- Melioidosis	Yes	No
- Pertussis	Yes	No
- Pneumococcal Disease (Invasive)	Yes	No
- Salmonellosis (non-typhoidal)	Yes	No
2. If supporting diagnosis report is not available, please advise us the medical justification to establish the diagnosis of serious infectious disease.		
3. Was the life assured hospitalized in the Intensive Care Unit (ICU) as a result of the serious infectious disease?	Yes	No
a. If No, please state the reason of ICU hospitalization:		
b. If Yes, please state the period of admission: _____ to _____		
4. Was the life assured quarantined by law a result of diagnosis related to pandemics and communicable diseases?	Yes	No

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

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

5.	Did the patient underwent surgery to any of the following vital organs? Please circle.		
a.	Heart	Yes	No
b.	Lung	Yes	No
c.	Brain	Yes	No
d.	Kidney	Yes	No
e.	Liver	Yes	No
f.	Others, please specify:		
g.	If Yes to Q4, please state actual date of surgery and type of surgery performed and attach a copy of surgical report. Type of Surgery : _____ Date : _____(DD/MM/YYYY)		

6.	Was the surgery performed on vital organs as a result of the following? Please circle.		
a.	Illness	Yes	No
b.	Accident	Yes	No
c.	Serious infectious disease	Yes	No

SECTION III

1.	Has the patient previously suffered from severe infectious disease? If Yes, please provide the following details:	Yes	No

Diagnosis	Date of diagnosis (dd/mm/yy)	Date when patient was informed of diagnosis	Name and date of treatments	Name and address of treating doctor

2.	Is there anything in patient's medical history which would have increased the risk of having severe infectious disease? If Yes, please provide the following details:	Yes	No

Diagnosis	Date of diagnosis (dd/mm/yy)	Date when patient was informed of diagnosis	Name and date of treatments	Name and address of treating doctor

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

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

3. Does the patient have or ever had any other significant medical condition? Please circle. If Yes, please provide the following details:				Yes	No
Diagnosis	**Date of diagnosis (dd/mm/yy)**	**Date when patient was informed of diagnosis**	**Name and date of treatments**	**Name and address of treating doctor**	

Name and Signature of the Medical Specialist who filled up **Section 2**	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.

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