PRUDENTIAL

PRUSafe Gift Claim Form

Important Note

1. The issue of this form is in no way an admission of liability.
2. The Company reserves the right to request for additional documents when deemed necessary.
3. Payment method for Claim Settlement will be via Direct Credit. Please fill in your bank details under Section 1 and submit a copy of the Life Assured's bank book or bank statement, stating the account holder's name and account number on the same page.

SECTION 1 (This section is to be completed by the Life Assured/Claimant.)

LIFE ASSURED'S PARTICULARS			
Full Name		NRIC No.	
Company			
Address		Postal Code	
Date of birth		Contact No.	
Email Address			
Name of Child (If claimant is Child)		Birth Cert No.	
Date of Birth			

Name of Account Holder (Life Assured)	Name of Bank	Bank Account Number

POLICY NUMBER

TYPE OF CLAIM
Mandatory documents for claim submission • **PRU**Safe Gift Claim Form

Claim Type (Please tick the appropriate box for the benefit type you are claiming)		**Additional Documents to be submitted together with the mandatory documents.**
☐	**Accident Death Benefit**	• Certified True Copy of Death Certificate • Coroner's Certificate • Post-Mortem Report • Newspaper article and Policy Report (if available) • NRIC of Claimant / Birth Certificate (If claimant is child) • Proof of Relationship (eg. Marriage Cert, Birth Cert, etc) Additional documents required for death occurred overseas: • Letter from Immigration & Checkpoints Authority (ICA) Singapore on the update of the life status to deceased for Singaporean/Singapore Permanent Resident • Copy of Burial or cremation certification/documents
☐	**Accidental Hospital Income / Additional Accidental ICU Income Benefit**	• A copy of the hospitalization bills • A copy of Inpatient Discharge Summary/Medical Report • Newspaper article and Policy Report (if available)

☐	**Medical Reimbursement due to Accident or Infectious Diseases Benefit**	• Doctor Memo confirming the diagnosis of Accident or Infectious Disease • Original Tax Invoices

1. Details of Illness

1.1. Describe fully the extent and nature of illness

1.2. Date symptoms first started		DD		MM		YY
1.3. Date first treated		DD		MM		YY

1.4. Is the illness still being treated? (Please circle) Yes / No

1.4.1. If YES, please state nature of ongoing treatment and approximate date of completion.	
1.4.2. If NO, please state date of last treatment or appointment.	

1.5. Has the illness been treated previously? (Please circle) Yes / No

1.5.1. If YES, please state date of previous treatment.		DD		MM		YY

1.5.2. Please state name and address of attending doctor for previous treatment.	

2. Details of Accident

2.1. Date of Accident		DD		MM		YY

2.2. Time of Accident	
2.3. Place of Accident	

2.4. Describe in detail how the accident happened. (Please enclose a copy of the police report, if any)

2.5. Please state in detail the injuries sustained.

2.6. Please state the date of first consultation. Please provide details of doctor(s) or hospital (s) consulted for this injury.

Name of Doctor	Name & Address of Clinic / Hospital	Dates of Consultation	Reason for Visit

2.7. Please state the reason if you did not seek treatment immediately after the accident.				
2.8 Was there a police report? If yes, please provide a copy. (Please circle)			Yes / No	
3. Death Abroad – Please complete this section if death occurred outside Singapore				
3.1 Date when deceased left Singapore.			(DD/MM/YYYY)	
3.2 Please state the purpose of the overseas visit				
3.3 What was the intended length of visit?				
3.4 Was the deceased's body repatriated back to Singapore for cremation / burial? Please provide a copy of the letter from Immigration and Checkpoints Authority (ICA).			Yes / No	
3.5 Please provide below, the name and address of the doctor certifying death:				
Name of doctor	Address of Doctor			
4. Other Information				
4.1 Date of hospitalisation	From (dd/mm/yy)	To (dd/mm/yy)		
4.2 Date of medical leave	From (dd/mm/yy)	To (dd/mm/yy)		
4.3 Was surgery performed? If YES, please provide details below. (Please circle)			Yes	No
Surgical Operation / Procedure	Date(s) of Operation / Procedure (dd/mm/yy)	Name & Address of Doctor(s) / Hospital(s)		
4.4 Are you claiming Medical Expenses from other sources? If YES, please provide details below. (Please circle)			Yes	No
Name of Insurance Company, Employer, Third Party etc.	Nature of Claim	Amount Claimed	Policy Number (if applicable)	

4.5 Please provide details of doctor(s) or hospital(s) admitted for this disability.

Name of Doctor	Name & Address of Clinic / Hospital	Dates of Consultation / Admission	Reason for Visit

4.6 Please provide details of doctor(s) you consulted for any disorder on or before this hospitalisation.

Name of Doctor	Name & Address of Clinic / Hospital	Dates of Consultation	Reason for Visit

DECLARATION, AUTHORISATION AND CONSENT

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 ("Prudential") 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 acknowledge and accept that Prudential expressly reserves its rights to require or obtain further information and documentation as it deems necessary.

4. I confirm that I have paid in full all the bill(s)/invoice(s)/receipt(s) that I have submitted to Prudential for reimbursement and have not claimed and do not intend to claim from other company(ies)/person(s).

5. For the purposes of (a) assessing, processing and investigating my claim(s) arising under the policy and such other purposes ancillary or related to the assessing, processing and investigating my claim(s) and administering of the policy, (b) customer servicing, statistical analysis, conducting customer due diligence, reporting to regulatory or supervisory authorities, auditing and recovery of any debts owing to Prudential Assurance Company Singapore (Pte) Limited ("**PACS**") under this policy, (c) storage and retention, (d) meeting requirements of prevailing internal policies of PACS, and (v) as set out in PACS Privacy Notice ("**Purpose**"), I authorise, agree and consent to:

(i) Any person(s) or organisation(s) that has relevant information concerning the policyowner and the life assured (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

(ii) Prudential collecting, using, disclosing, releasing, transferring and exchanging personal data about me, the policyowner and the life assured, with any 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 assisting with my claim for the Purpose.

6. 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 or where applicable, the consent of the legal personal representative of the deceased life assured, 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.

7. 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.

8. I understand that if I am a 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.

9. I understand and agree that a photocopy of this authorisation shall be as valid as the original.

Signature of Life Assured / Claimant	Date

The following section is to be completed if the Claimant is not the Life Assured.

Name of Claimant		NRIC of Claimant	
Email Address			
Address			
Relationship to deceased		Contact No.	