

HOSPITAL CARE 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

3.1 Please tick the appropriate box for the Hospital Care / Medical Conditions you are claiming.

HOSPITAL CARE (CHILD)		HOSPITAL CARE (MOTHER)	
Incubation of newborn child for more than 3 consecutive days immediately following birth		Hospitalisation of life assured (mother) due to Zika	
Premature birth requiring neonatal ICU			
Hospitalisation of child due to Hand, Foot, Mouth Disease			
Hospitalisation of life assured's child due to Zika			

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.

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 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, (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 this 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) or organisation(s) listed in 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.
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 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.
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.			

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

**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

<p>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</p> <p>_____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)</p>	Yes	No
<p>Please complete Question 4 if the patient's condition is on: Hospitalisation of child due to Hand, Foot, Mouth Disease</p>		
<p>4. Was the child hospitalised for Hand, Foot and Mouth Disease? If yes, please state the period of confinement</p> <p>_____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)</p>	Yes	No
<p>Please complete Question 5 to 6 if patient's condition is on: Hospitalisation of life assured's child due to Zika</p>		
<p>5. Was the child admitted to hospital as a result of Zika? If yes, please state the period of confinement</p> <p>_____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)</p>	Yes	No
<p>6. Was the hospitalization due to complications of Zika (eg. microcephaly)?</p>	Yes	No
<p>If yes, please provide details.</p>		
<p>Please complete Question 7 if the patient's condition is on: Hospitalisation of life assured (mother) due to Zika</p>		
<p>7. 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</p> <p>_____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)</p>	Yes	No
<p>SECTION III</p>		
<p>8. 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.</p> <p>_____ (DD/MM/YYYY)</p>	Yes	No
<p>9. Is the diagnosis related to the consumption of any intoxicating liquor, drugs or poison, suicide or attempted suicide or intentional self-injury?</p>	Yes	No

If yes, please provide details.		
10. 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.		
11. Was this pregnancy conceived through in-vitro fertilisation? If YES, please state the number of foetus conceived : _____	Yes	No
12. Was the child conceived through a pregnancy, which carried 3 or more babies?	Yes	No
SECTION IV		
13. 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.		
14. 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 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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