# CRISIS COVER CLAIM FORM

## SPECIAL BENEFIT (Special Medical Conditions and Juvenile Medical Conditions)

**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)**

### DETAILS OF POLICY

Policy Number(s) the benefit(s) you would like to claim:

### DETAILS OF LIFE ASSURED

| | | | | | |
|---|---|---|---|---|---|
| Full Name | | | | | |
| NRIC / Passport No. | | Date of birth | | Gender | |
| Address | | | | | |
| Contact No. | | | Email address | | |
| Occupation | | | Name and address of Employer | | |

### TYPE OF CLAIM

1. Please tick [√] in the appropriate box for the Special and Juvenile Medical Conditions you are claiming on the above policy(ies).

☐ **Special Medical Conditions**

- ☐ Diabetic Complications
- ☐ Osteoporosis with Fractures
- ☐ Severe Rheumatoid Arthritis

☐ **Juvenile Medical Conditions**

- ☐ Glomerulonephritis with Nephrotic Syndrome
- ☐ Insulin Dependent Diabetes Mellitus
- ☐ Osteogenesis Imperfecta
- ☐ Still's Disease
- ☐ Haemophilia A and Haemophilia B
- ☐ Kawasaki Disease with heart complications
- ☐ Rheumatic Fever with valvular impairment
- ☐ Wilson's Disease

### DETAILS OF ILLNESS / MEDICAL CONDITION

2. Describe fully the signs or symptoms for which Life Assured has consulted doctor or received treatment.

C010519

| | | | | | | |
|---|---|---|---|---|---|---|
| 3. Date when signs or symptoms first started | | DD | | MM | | YY |
| 4. Date when Life Assured first consulted a doctor for the above signs or symptoms. | | DD | | MM | | YY |

5. Please provide the following details accordingly if the consultation was due to illness or accident.

| If consultation was for illness, describe fully the nature and extent of illness in terms of its diagnosis and treatment received. | If consultation was due to accident, describe fully the date of accident, how and where did the accident occur. | | |
|---|---|---|---|
| | Was the accident reported to the police? | Yes | No |
| | If yes, please provide:<br>• the name of police officer and police station at which the accident was reported; and<br>• a copy of the police report. | | |

| 6. Has Life Assured previously suffered from or received treatment for a similar or related illness / injury? | Yes | No |
|---|---|---|
| If yes, please give details. | | |

7. Please provide the details of all doctors or specialists whom Life Assured has consulted in connection with his/her illness/injury:-

| Name of Doctor | Name and Address of Clinic / Hospital | Dates of consultation | Reason(s) for consultation |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

8. Please provide the details of Life Assured's regular doctor and company doctor whom he/she has 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 | Reason(s) for consultation |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**OTHER INSURANCE**

9. Does Life Assured have similar benefits with any other company? If yes, please give full details :-

| Name of Insurer | Type of Plan | Date of Issue | Sum Assured |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**PAYMENT METHOD FOR CLAIM SETTLEMENT**

10. Please tick one of the boxes below to indicate your preferred payment method.

☐ 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 dollar bank account
(*if you select this payment mode, you need to* ***submit*** *a copy of the bank book 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<br>(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

**SPECIAL BENEFIT (Special Medical Conditions and Juvenile Medical Conditions)**

**(To be completed by the Life Assured's attending medical specialist)**

Please tick [√] in the appropriate box and complete the relevant sections in respect to the medical conditions claims. Please submit ONLY the relevant sections to us upon completion.

| Special Medical Conditions | Sections to completed |
|---|---|
| ☐ Diabetic Complications | 1, 2, 13 |
| ☐ Osteoporosis with Fractures | 1, 3, 13 |
| ☐ Severe Rheumatoid Arthritis | 1, 4, 13 |

| Juvenile Medical Conditions | Sections to completed |
|---|---|
| ☐ Glomerulonephritis with Nephrotic Syndrome | 1, 5, 13 |
| ☐ Haemophilia A and Haemophilia B | 1, 6, 13 |
| ☐ Insulin Dependent Diabetes Mellitus | 1, 7, 13 |
| ☐ Kawasaki Disease with heart complications | 1, 8, 13 |
| ☐ Osteogenesis Imperfecta | 1, 9, 13 |
| ☐ Rheumatic Fever with valvular impairment | 1, 10, 13 |
| ☐ Stills's Disease | 1, 11,13 |
| ☐ Wilson's Disease | 1, 12, 13 |

| | | | |
|---|---|---|---|
| Name of Specialist | | MCR No. | |
| Field of Specialty | | | |
| Name of Medical Institution | | | |

**SECTION 1 : GENERAL INFORMATION**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. Date when patient first consulted you for the condition? | | DD | | MM | | YY |
| 2. When was the last consultation? | | DD | | MM | | YY |
| 3. What were the presenting symptoms when you first saw the patient? | | | | | | |
| 4. When did the above symptoms first present? | | DD | | MM | | YY |
| 5. Please provide exact diagnosis: | | | | | | |
| 6. What is/are the underlying cause(s)? | | | | | | |
| 7. Date of diagnosis | | DD | | MM | | YY |
| 8. Date when patient/patient's next of kin first informed of the diagnosis. | | DD | | MM | | YY |

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 9. Please provide dates and details of investigation performed for the diagnosis. Kindly attach copies of all relevant objective test reports, which confirmed the diagnosis. | | | | | | | |
| 10. Were you the doctor who first diagnosed the patient with this condition? Please circle. | | | | | | Yes | No |
| 11. If Yes, over what period do your records extend? | | | From (dd/mm/yy) | | | To (dd/mm/yy) | |
| 12. 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 or had treated the patient for this condition: | | | | | | | |
| b. Date the diagnosis was made by the previous doctor. | | DD | | MM | | | YY |
| c. When was the referral made for the patient to see you? | | DD | | MM | | | YY |
| d. What was the reason for referral to see you? Please attach a copy of the referral letter. | | | | | | | |
| **SECTION 2 : DIABETIC COMPLICATIONS** | | | | | | | |
| 1. When was the diabetes diagnosed? | | DD | | MM | | | YY |
| 2. Please provide a description of the extent of patient's diabetes. | | | | | | | |
| 3. What treatment has been prescribed? | | | | | | | |
| 4. Name and practice address of the doctor that the patient is seeing for management of his/her diabetes. | | | | | | | |
| 5. Please give details of recent blood sugar levels. | | | | | | | |
| 6. Is there evidence of diabetic retinopathy? If Yes, please provide the following: | | | | | | Yes | No |
| a. Please circle which of the eye is affected by diabetic retinopathy? | | | **Left Eye** | | | **Right Eye** | |
| b. Using the Snellen eye chart, what is the best possible corrected visual acuity of both eyes? | | | Left eye | | | Right eye | |
| c. Does patient require laser treatment for his/her diabetic retinopathy? | | | | | | Yes | No |
| i. If laser treatment had been given, please state the date(s) of such treatment. | | DD | | MM | | | YY |

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

| | | |
|---|---|---|
| d. Is such treatment absolutely necessary? | Yes | No |
| If No, please specify what alternative treatment is available for the patient's condition? | | |
| e. Please provide results of investigations done and attach copies of the fluorescent fundus angiography report. | | |
| 7. Is there evidence of diabetic nephropathy? If Yes, please provide the following: | Yes | No |
| a. Is there decreased renal function of less than eGFR less than 30 ml/min/1.73m$^2$? | Yes | No |
| Please provide the eGFR readings, including dates of assessment. | | |
| b. Is there ongoing proteinuria greater than 300 mg/24 hours | Yes | No |
| Please provide the proteinuria readings, including dates of assessment. | | |
| c. Please provide the results of investigations done and attach copies of renal function test and urinalysis reports. | | |
| 8. Has the patient undergo any amputation due to diabetes? If Yes, please provide the following: | Yes | No |
| a. Please state the underlying cause for the amputation. | | |
| b. Please state the site/area of amputation. | | |
| c. Please state name and type of surgery patient has undergone. | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| d. Please state exact date of surgery? | | DD | | MM | | YY |

| | |
|---|---|
| e. Please state the name and address of hospital where the surgery was performed. | |
| Signature & Practice Stamp of the Medical Specialist who filled up **Part II** | Date |

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

| **SECTION 3 : OSTEOPOROSIS WITH FRACTURES** | | |
|---|---|---|
| 1. Is there evidence of osteoporosis with a bone density reading T-score of less than -2.5? | Yes | No |
| 2. Please provide results of patient's bone density T-score readings, including dates of assessment? | | |
| 3. Is there osteoporotic fractures involving femur, wrist or vertebrae? If Yes, please provide the following: | Yes | No |
| a. Was there history of three or more osteoporotic fractures? | Yes | No |
| b. Please specify the bodily site of fracture and the corresponding dates of fractures to these bones. | | |
| 4. Have the osteoporotic fractures <u>directly caused</u> the patient unable to perform (whether aided* or unaided) the following Activities of Daily Living?<br>*Aided shall mean with the aid of special equipment, device and/or apparatus and not pertaining to human aid. | Yes | No |

| **Activity** | **Please circle if the patient can perform the listed activity?** | | **Period of inability to perform** | |
|---|---|---|---|---|
| | | | **From (dd/mm/yy)** | **To (dd/mm/yy)** |
| **Washing** : Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means. | Yes | No | | |
| **Dressing** : Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances. | Yes | No | | |
| **Transferring** : Ability to move from a bed to an upright chair or wheelchair and vice versa. | Yes | No | | |
| **Mobility** : Ability to move indoors from room to room on level surfaces. | Yes | No | | |
| **Toileting** : Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain satisfactory level of personal hygiene. | Yes | No | | |
| **Feeding** : Ability to feed oneself once food has been prepared and made available. | Yes | No | | |

| **SECTION 4 : SEVERE RHEUMATOID ARTHRITIS** | | |
|---|---|---|
| 1. Is there evidence of widespread join destruction with major clinical deformity of the joint areas of: | | |
| a. Hands? | Yes | No |
| b. Wrists? | Yes | No |
| c. Elbows? | Yes | No |
| d. Spine? | Yes | No |
| e. Knee? | Yes | No |
| f. Ankle? | Yes | No |
| g. Feet? | Yes | No |
| If Yes to any of the above, please provide more details to your answer. | | |

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

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

| | | | |
|---|---|---|---|
| 2. | Has the patient suffered from any of the following symptoms? | | |
| | a. Morning stiffness? | Yes | No |
| | b. Symmetric arthritis? | Yes | No |
| | c. Presence of rheumatoid nodules? | Yes | No |
| 3. | Is there evidence of elevated titres of rheumatoid factors? | Yes | No |
| 4. | Please state the results of investigations done and attach a copy of the test reports showing elevated titres of rheumatoid factors. | | |

**SECTION 5 : GLOMERULONEPHRITIS WITH NEPHROTIC SYNDROME**

| | | | |
|---|---|---|---|
| 1. | Please confirm if the patient has nephrotic syndrome. | Yes | No |
| | a. If Yes, please advise the duration syndrome has persisted with or without intervening periods of remission. | months | |
| 2. | Please describe any treatment regimen prescribed to the patient. | | |
| | a. Please state the period of this treatment regimen. | From (dd/mm/yy) | To (dd/mm/yy) |
| | b. What is the purpose of this treatment regimen? | | |
| | c. Has the patient been following this course of treatment or is the patient non-compliant? | | |
| 3. | Please provide the results and attach a copy of investigations done (if any). | | |

**SECTION 6 : HAEMOPHILIA A AND HAEMOPHILIA B**

| | | | |
|---|---|---|---|
| 1. | Please state the type of haemophilia. | | |
| 2. | Is there a factor VIII or factor IX activity less than 1%? | Yes | No |
| 3. | Please provide details on how diagnosis Haemophilia A and Haemophilia B was first made? | | |
| 4. | Please describe the treatment regimen prescribed to the patient. | | |
| | a. Please state the period of this treatment regimen. | From (dd/mm/yy) | To (dd/mm/yy) |
| | b. Has the patient been following this course of treatment or is the patient non-compliant? | | |
| 5. | Please provide details of all investigations performed.<br>Please attach a copy of the laboratory, X-rays, haematology reports, blood test reports, bone marrow reports, etc. | | |

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

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

| **SECTION 7 : INSULIN DEPENDENT DIABETES MELLITUS** | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. Please provide full and exact details of the diagnosis of Insulin Dependent Diabetes Mellitus. | | | | | | | |
| 2. Was the patient dependent on exogenous insulin? | | | | | | Yes | No |
| a. How long has the patient been dependent on exogenous insulin? | | | | | | | months |
| b. Please provide date of onset of dependence. | | DD | | MM | | | YY |
| 3. What are the types of insulin used by the patient? Please provide brand name. | | | | | | | |
| 4. Please provide details on dosage and frequency and sites of insulin injection. | | | | | | | |
| 5. Please provide details on results of blood or urine testing. If possible, please also give the HbA1c results. | | | | | | | |
| 6. Please provide details with dates of instances where the patient had diabetic coma. | | | | | | | |
| 7. Please provide details of all investigations performed and treatment prescribed.<br>Please also attach a copy of the laboratory investigation results. | | | | | | | |

| **SECTION 8 : KAWASAKI DISEASE WITH HEART COMPLICATIONS** | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. Please provide full and exact details of the diagnosis of Kawasaki with Heart Complications. | | | | | | | |
| 2. Is there evidence of dilation or aneurysm formation in the coronary arteries? If Yes, please advise the following: | | | | | | Yes | No |
| a. Please describe results if investigation and attach a copy of the investigation tests performed confirming this. | | | | | | | |
| b. What is the duration of the coronary artery dilation or aneurysm formation? | | | | | | | months |
| c. What is the date of onset? | | DD | | MM | | | YY |

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

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

| **SECTION 9 : OSTEOGENESIS IMPERFECTA** | | |
|---|---|---|
| 1. Does the patient have progressive kyphoscoliosis? | Yes | No |
| 2. Please provide full and exact details of the diagnosis of Osteogenesis Imperfecta with the type? | | |
| 3. Please provide details on how diagnosis Osteogenesis Imperfecta was first made? | | |
| 4. Is there a diagnosis confirmed by using a skin punch biopsy? | Yes | No |
| a. If Yes, what is the biopsy findings and to attach a copy of the report. | b. If No, please clarify why skin punch biopsy is not required? | |
| 5. Is the patient suffering with growth retardation and hearing impairment? | Yes | No |
| If Yes, please provide details to your answer. | | |
| 6. Is there any multiple fractures of bones present in the X-ray studies? | Yes | No |
| If Yes, please provide details to your answer and to state the fracture bones. | | |
| 7. Please describe the treatment regimen prescribed to the patient. | | |
| c. Please state the period of this treatment regimen. | From (dd/mm/yy) | To (dd/mm/yy) |
| d. Has the patient been following this course of treatment or is the patient non-compliant? | | |
| 8. Please provide the results of investigations done including the result of physical examination, result of x-ray and biopsy report. | | |

| **SECTION 10 : RHEUMATIC FEVER WITH VALVULAR IMPAIRMENT** |
|---|
| 1. Please provide a description of the extent of Rheumatic Fever with Valvular Impairment. |
| 2. Please state which of the Jones Criteria for diagnosis of rheumatic fever the patient satisfies. |

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

| | | |
|---|---|---|
| 3. Please provide details with supporting evidence of any streptococcal infection. | | |
| 4. Is there any heart valve incompetence? | Yes | No |
| a. If Yes, please state valve(s) involved with details including degree of incompetence. | | |
| b. What is the cause of the heart valve incompetence? | | |
| c. Is the heart valve incompetence attributable to rheumatic fever? | | |
| d. Please provide results of quantitative investigations on heart valve function. | | |
| 5. Please provide details of all investigations performed and treatment prescribed. Please attach a copy of the laboratory investigation results. | | |

**SECTION 11 : STILL'S DISEASE**

| | | |
|---|---|---|
| 1. Please advise if there is evidence of the following on the diagnosis of Still's Disease: | | |
| a. Onset of arthritis after 1 month of systemic illness and high fever? | Yes | No |
| b. High spiking, daily (quotidian) fever? | Yes | No |
| c. Evanescent rash? | Yes | No |
| d. Arthritis? | Yes | No |
| e. Splenomegaly? | Yes | No |
| f. Lymphadenopathy? | Yes | No |
| g. Serositis? | Yes | No |
| h. Weight loss? | Yes | No |
| If Yes, please state how much weight loss recorded per month. | | |
| i. Neutrophilic leukocytosis? | Yes | No |
| j. Increase acute phase proteins and sero-negative tests for Antinuclear Antibodies (ANA) and Rheumatoid Factor (RF)? | Yes | No |
| If Yes to any of the above, please provide more details to your answer. | | |
| 2. Please provide details on how diagnosis was first made? | | |
| 3. Is there documentation of the condition for at least 6 months? | Yes | No |
| 4. Please provide the results of investigations done including the 6 months' period of documentation. | | |

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

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

| **SECTION 12 : WILSON'S DISEASE** | | | | | | |
|---|---|---|---|---|---|---|
| 1. Please provide full and exact details of the diagnosis of Wilson's Disease. | | | | | | |
| 2. Date of the diagnosis. | | DD | | MM | | YY |
| 3. Please provide details on how diagnosis of Wilson's Disease was first made. Please provide the liver biopsy impression in details. | | | | | | |
| 4. Is the patient suffering from any neurological symptoms? | | | | | Yes | No |
| If Yes, please describe in details. | | | | | | |
| 5. Please describe the treatment regimen prescribed to the patient. | | | | | | |
| 6. Please state the start date of chelating agent prescribed to the patient. | | DD | | MM | | YY |
| 7. How many months the child is under the chelating agents? | | | | | | months |
| 8. Please provide results of the documentary proof supporting your answer in Q7. | | | | | | |
| 9. Has the patient been following this course of treatment or is the patient non-compliant? | | | | | | |

| **SECTION 13 : OTHER INFORMATION** | | |
|---|---|---|
| 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's condition or surgery performed in any way related or due to:- | | |
| a. AIDS, AIDS-related complex or infection by HIV? | Yes | No |
| b. Drug abuse or use of drug not prescribed by registered medical practitioner? | Yes | No |
| c. Alcohol abuse or misuse? | Yes | No |
| d. Congenital anomaly or defect? | Yes | No |

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| e. Attempted suicide or self-inflicted injuries? | | | | | | Yes | No |
| **If Yes for any of the above, please provide the following details and also attach a copy of the test result.** | | | | | | | |
| f. Please indicate the diagnosis date. | | DD | | MM | | YY | |
| g. Name and practice address of the doctor who first diagnosed the patient with HIV, AIDS, drug abuse, alcohol abuse or congenital anomaly. | | | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 3. Has the patient previously suffered from or received treatment for a similar/related illness? If Yes, please provide the following details. | | | | | Yes / No |
| **Diagnosis** | **Date of diagnosis** | **Date when patient was informed of diagnosis** | **Name and date of treatments** | **Name and address of treating doctor** | |
| | | | | | |
| 4. Is there anything in the patient's medical history which would have increased the risk of his/her condition? | | | | | Yes / No |
| If Yes, please state the details. | | | | | |
| 5. Does the patient have or ever had any other significant health condition? If Yes, please provide the following details. | | | | | Yes / No |
| **Diagnosis** | **Date of diagnosis** | **Date when patient was informed of diagnosis** | **Name and date of treatments** | **Name and address of treating doctor** | |
| | | | | | |
| 6. Is there anything in the patient's medical history which would have increased the risk of his/her condition? | | | | | Yes / No |
| If Yes, please state the details. | | | | | |
| 7. Does the patient have or ever had any other significant health condition? If Yes, please provide the following details. | | | | | Yes / No |
| **Diagnosis** | **Date of diagnosis** | **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 **Part II** | Date |
| Practice Stamp of the Medical Specialist | |

# 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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