PRUDENTIAL

PruCustomer Line: 1800 -333 0 3333

CRISIS COVER CLAIM FORM

Stroke / Brain Aneurysm Surgery / Cerebral Shunt Insertion / Carotid Artery Surgery

Important Notes

1. Please note that, under the policy terms and conditions, 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.

SECTION 1

(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 the appropriate box for the Critical Illness / Medical Conditions you are claiming.

☐ Stroke ☐ Brain Aneurysm Surgery

☐ Cerebral Shunt Insertion ☐ Carotid Artery Surgery

DETAILS OF ILLNESS / MEDICAL CONDITION

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

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

C010519

5. Has Life Assured previously suffered from or received treatment for a similar or related illness / injury?	Yes	No

If yes, please give details.

6. 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

7. 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

8. 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

9. 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 (Policyowner to sign if Life Assured is below age 18 years)	Date and signature of Policyowner

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

SECTION 2 MEDICAL SPECIALIST REPORT

STROKE / BRAIN ANEURYSM SURGERY / CEREBRAL SHUNT INSERTION / CAROTID ARTERY SURGERY

(To be completed by the Life Assured's attending neurologist)

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

Part I

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 was informed of the diagnosis.		DD		MM		YY
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.						

Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**	Date

10. Were you the doctor who first diagnosed the patient with this condition? Please circle.						Yes	No
11. If yes to Question 10, 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?							
d. What was the reason for referral to see you? Please attach a copy of the referral letter.							

PART II

1. Please describe the initial episode regarding the onset of the patient's stroke condition as follows:-							
a. Date of initial episode.		DD		MM		YY	
b. Nature of episode.							
c. Duration of acute symptoms.							
d. Has there been an infarction of brain tissue, cerebral and subarachnoid haemorrhage, intracerebral embolism and cerebral thrombosis? Please circle.						Yes	No
e. Has the patient returned or is the patient able to return to his/her normal duties? Please circle.						Yes	No
If Yes, please state the date patient has returned or is expected to return to his/her normal duties. (dd/mm/yy)	If No, please state the patient's current physical and mental limitations that prevent him/her from returning to work. Please make reference to the date of your assessment.						
f. Are the investigations or findings consistent with the diagnosis of a new Stroke? Please circle.						Yes	No
If Yes, please provide details and **attach copies** of all reports, CT Scan, MRI, laboratory test results, etc which confirmed the diagnosis in Section 3 of this medical questionnaire.							

Signature & Practice Stamp of the Neurologist who filled up **Section 2**	Date

Permanent neurological deficit with persisting clinical symptoms means symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the lifetime of the Life Assured. Symptoms that are covered include numbness, paralysis, localized weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

g. Was there evidence of permanent neurological deficit lasting for at least 6 weeks after the date of stroke diagnosis? Please circle.	Yes	No

h. If Yes, please tick accordingly and to provide the details if the following neurological deficit with persisting clinical symptoms exists.

Please tick	Symptom of dysfunction in the nervous system	Date of last assessment (dd/mm/yy)	Please specify the exact body parts involved	Is the symptom expected to last throughout the lifetime of the patient?		Please elaborate with supporting evidence
	Numbness			Yes	No	
	Paralysis			Yes	No	
	Localised Weakness			Yes	No	
	Dysarthria (difficulty with speech)			Yes	No	
	Aphasia (inability to speak)			Yes	No	
	Dysphagia (difficulty swallowing)			Yes	No	
	Visual Impairment			Yes	No	
	Difficulty in walking			Yes	No	
	Lack of coordination			Yes	No	
	Tremor			Yes	No	
	Seizures			Yes	No	
	Dementia			Yes	No	

Signature & Practice Stamp of the Neurologist who filled up **Section 2**	Date

Please tick	Symptom of dysfunction in the nervous system	Date of last assessment (dd/mm/yy)	Please specify the exact body parts involved	Is the symptom expected to last throughout the lifetime of the patient?		Please elaborate with supporting evidence
	Delirium			Yes	No	
	Coma			Yes	No	
	Others, please specify:			Yes	No	
	Others, please specify:			Yes	No	

2. Was the diagnosis of Stroke classified as any of the following? Please circle.		
a. Transient Ischaemic Attacks?	Yes	No
b. Brain damage due to an accident or injury?	Yes	No
c. Brain damage due to an infection?	Yes	No
d. Brain damage due to vasculitis?	Yes	No
e. Brain damage due to inflammatory disease?	Yes	No
f. Vascular disease affecting the eye?	Yes	No
g. Vascular disease affecting the optic nerve?	Yes	No
h. Ischaemic disorders of the vestibular system?	Yes	No
3. Has the patient undergone any Brain Aneurysm Surgery? Please circle.	Yes	No

Signature & Practice Stamp of the Neurologist who filled up **Section 2**	Date

4. Was surgery done via craniotomy? Please circle. If Yes, please provide the following details.						Yes	No
a. Please indicate the date of surgical craniotomy.		DD		MM			YY
b. For what purpose was it done?							
i) To repair an intracranial aneurysm? Please circle.						Yes	No
ii) To remove an arterio-venous malformation? Please circle.						Yes	No
5. If surgical craniotomy was not performed, was surgery done via endovascular repair or procedure? Please circle.						Yes	No
6. Was an arteriography / cerebral angiogram carried out? Please circle.						Yes	No
If Yes, please state the date of cerebral arteriogram, its findings and provide a copy of the reports.	If No, please state and provide a copy of any other appropriate diagnostic test that is available						
7. Has the patient undergone any Cerebral Shunt Insertion? Please circle.						Yes	No
8. Was there surgical insertion of a shunt from the ventricles of the brain? Please circle.						Yes	No
If Yes, please indicate the date of shunt insertion.		DD		MM			YY
9. Was there raised pressure in the cerebrospinal fluid? Please circle.						Yes	No
If Yes, what is/are the underlying cause(s) of hydrocephalus?							
10. Was there any intracranial pressure giving rise to neurological deficit as a result of the hydrocephalus? Please circle.						Yes	No
If Yes, please indicate the neurological deficit(s).							

Signature & Practice Stamp of the Neurologist who filled up **Section 2**	Date

11. Did the patient suffer from narrowing of the Carotid Artery? Please circle. If Yes, please provide details.		Yes	No
Please indicate the date of surgical endarterectomy. (dd/mm/yy)	Please state the percentage of narrowing of the carotid artery.		
12. Was an arteriography / angiogram carried out to establish the diagnosis of carotid artery stenosis? Please circle.		Yes	No
If Yes, please state the findings and provide a copy of the arteriography / angiogram report.	If No, please state and provide a copy of any other appropriate diagnostic test that is available		
Part III			
1. Has the patient's condition resulted in him/her to be physically or mentally disabled from ever continuing in any employment? Please circle. 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? Please circle.		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? Please circle.		Yes	No
b. Drug abuse or use of drug not prescribed by registered medical practitioner? Please circle.		Yes	No
c. Alcohol abuse or misuse? Please circle.		Yes	No
d. Congenital anomaly or defect? Please circle.		Yes	No
e. Attempted suicide or self-inflicted injuries? Please circle.		Yes	No

Signature & Practice Stamp of the Neurologist who filled up **Section 2**	Date

If Yes for any of the above, please provide the following details and also provide a copy of the investigation test result.

Exact diagnosis	Date of diagnosis (dd/mm/yy)	Name and practice address of treating doctor

3. Has the patient previously suffered from stroke or any related illnesses (e.g. hypertension, transient ischaemic attack, angina or other cardiovascular diseases)? 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 having a stroke, intracranial aneurysm, arterio-venous malformation, hydrocephalus or narrowing of carotid artery? Please circle.	Yes	No
If Yes, please state the details.		
5. Does the patient have or ever had any other significant health condition? Please circle. 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 Neurologist who filled up **Section 2**	Date
Practice Stamp of the Neurologist	

SECTION 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.

1. CT scan
2. MRI scan results

Prudential Assurance Company Singapore (Pte) Limited (Reg. No.: 199002477Z)
Postal Address: Robinson Road P.O. Box 492, Singapore 900942
Tel: 1800 – 333 0 333 Fax: 6734 9555 Website: www.prudential.com.sg
Part of Prudential Corporation plc