CRISIS COVER CLAIM FORM

Major Cancer / Carcinoma in situ of specified organs / Early Prostate Cancer / Early Thyroid Cancer / Early Bladder Cancer / Early Chronic Lymphocytic Leukaemia / Early Melanoma / Gastro-intestinal Stromal Tumour (GIST) / Carcinoma in situ of specified organs treated with Radical Surgery / Cancer Treatment

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.
4. This form is required to be completed by the life assured and/ or the policy owner. Where it is necessary for the Next of Kin ("NOK") to sign on behalf of the life assured and/ or the policy owner, PACS will require additional information on the reason for this request and supporting documents to be submitted to our satisfaction to accept this request. If the life assured/ policy owner is deemed mentally incapacitated and/or there is any medical evidence and/or evidence of mental incapacitation, PACS will and/or may also require a court order or a Lasting Power of Attorney ("LPA") to be submitted for our assessment.

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.

- ☐ Major Cancers
- ☐ Major Organ (Lung) Transplantation
- ☐ Major Organ (Liver) Transplantation
- ☐ Major Organ (Pancreas) Transplantation
- ☐ Bone Marrow Transplantation
- ☐ Carcinoma in situ of specified organs
- ☐ Early Prostate Cancer
- ☐ Early Thyroid Cancer
- ☐ Early Bladder Cancer
- ☐ Early Chronic Lymphocytic Leukaemia
- ☐ Early Melanoma
- ☐ Gastro-intestinal Stromal Tumor (GIST)
- ☐ Carcinoma in situ of specified organs treated with Radical Surgery
- ☐ Cancer Treatment (Chemotherapy, Radiotherapy, Radiation Surgery or Radiosurgery, Targeted Therapy, Immunotherapy, Radical 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		YYYY
4. Date when Life Assured first consulted a doctor for the above signs or symptoms		DD		MM		YYYY
5. Has Life Assured previously suffered from or received treatment for a similar or related illness / injury? Please circle.					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. Is Life Assured insured for 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

Note:
1. All claim payments in Singapore Dollars (SGD) will be made via **PayNow (NRIC/FIN)** or **Direct Credit** only.
2. If no option is selected, payment will be made via **PayNow (NRIC/FIN)** by default.
3. For policies with **joint owners, joint trustees, or joint assignees**, **Direct Credit with joint bank account details is required**.
4. For **overseas payments** or payments in **foreign currencies**, please select **Telegraphic Fund Transfer**.

☐ **PayNow NRIC/FIN (Default Payment Method)**

- To ensure a smooth and timely payout, the PayNow account registered for this payment must be **linked to the NRIC/FIN**.
- Please submit a **copy of the Account Holder's NRIC or identity document**, showing the name and NRIC/FIN number.

To register for PayNow
1. Log in to your bank's internet or mobile banking account
2. Sign up for PayNow
3. Link your PayNow to your NRIC/FIN

☐ **Direct Credit**

Account Holder's Name	Name of Bank	Bank Account Number

- Please submit a copy of the **bank book or bank statement**, stating the **Account Holder's Name and bank account number**. We accept bank statements with balances and transactions blacked out, as well as truncated e-statements downloaded from the bank's mobile application, provided that the document shows the **Account Holder's Name and bank account number on the same page**.
- If the copy of the bank book or bank statement is not submitted, or the details cannot be verified, payment will be made via **PayNow (NRIC/FIN)** by default.

☐ **Telegraphic Fund Transfer**

Account Holder's Name	Bank Account Number	Swift Code
Currency Requested	**Name of Bank**	**Bank Address ****
Additional Information (If Applicable)***		

**Bank Address needs to include all relevant information e.g. Unit/Floor no., Building/Street Name, State Code & Country.
***Please provide a relevant code/number under the Additional Information column if currency is listed below.

- Please submit a copy of the **bank book or bank statement**, stating the **Account Holder's Name and bank account number**. We accept bank statements with balances and transactions blacked out, as well as truncated e-statements downloaded from the bank's mobile application, provided that the document shows the **Account Holder's Name and bank account number on the same page**.
- Charges incurred for **Telegraphic Fund Transfer requests** will be deducted from the payment amount.

Currency	Additional Information (Code/Number)
Australia Dollar (AUD)	BSB Code
Euro Dollar (EUR)	IBAN Code
Pound Sterling (GBP)	IBAN & Sorting Code
US Dollar (USD)	ABA Routing Number
India Rupee (INR)	IFSC Code

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

SECTION 2 - MEDICAL SPECIALIST REPORT

Major Cancer / Carcinoma in situ of specified organs / Early Prostate Cancer / Early Thyroid Cancer / Early Bladder Cancer / Early Chronic Lymphocytic Leukaemia / Early Melanoma / Gastro-intestinal Stromal Tumour (GIST) / Carcinoma in situ of specified organs treated with Radical Surgery / Cancer Treatment

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

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

Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**	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 to Question 10, over what period do your records extend?	From (DD/MM/YYYY)			To (DD/MM/YYYY)		
12. If you are not the first doctor who diagnosed the patient with this condition, please provide:						
a. Name and address of the doctor who first made the diagnosis or had treated the treated the patient for this condition.						
b. Date the diagnosis was made by the previous doctor.		DD		MM		YYYY
c. When was the referral made for the patient to see you?		DD		MM		YYYY
d. What was the reason for referral to see you? Please attach a copy of the referral letter.						
e. Please provide name and address of referral doctor.						
13. Please indicate the primary and exact anatomical site of the tumor						
14. Is the tumor malignant? Please circle.					Yes	No
a. If Yes, please confirm if there is histological evidence of uncontrolled growth of malignant cells with invasion and destruction of normal tissue? Please circle. **(Please attach the histology report in Section 3 of this medical questionnaire.)**					Yes	No
b. If histological evidence is not available, please advise us the medical justification to establish the diagnosis of malignant tumor.						
Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**				Date		

15. What is the staging of the tumor based on TNM Classification?
If the tumor has no TNM Classification, please advise us the type of staging / grading system (e.g. RAI staging, Clark Level, FIGO system, etc.) used to stage the tumor and its equivalent classification in TNM staging system:

a. Was the disease completely localized? Please circle.	Yes	No
b. Was there invasion of adjacent tissues? Please circle.	Yes	No
c. Were regional lymph nodes involved? Please circle.	Yes	No
d. Were there distant metastases? Please circle.	Yes	No

If Yes to Question (d), please provide full details, including site of metastases:

16. Was the diagnosis of cancer derived based on the finding of tumor cells and/ or tumor-associated molecules in blood, saliva, faeces, urine or any other bodily fluid in the absence of further verifiable evidence?	Yes	No

17. Please circle your reply to Question (a) to (h) below if the tumor was histologically classified as any of the following?

a. Was the diagnosis of tumor Benign?	Yes	No
b. Was the diagnosis of tumor Pre-malignant?	Yes	No
c. Was the diagnosis of tumor Carcinoma-in-situ (Tis) or Ta?	Yes	No
d. Was the diagnosis classified as any grades of dysplasia, squamous intraepithelial lesions (HSIL and LSIL) and intraepithelial neoplasia?	Yes	No

If Yes to Question (d) and the diagnosis was Cervical Intraepithelial Neoplasia (CIN), please state the exact CIN category and if there is pathologic evidence of carcinoma in situ:

e. Was the diagnosis of tumor having borderline malignancy?	Yes	No
f. Was the diagnosis of tumor having any degree of malignant potential?	Yes	No

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

g. Was the diagnosis of tumor having suspicious malignancy?	Yes	No
h. Was the diagnosis of tumor classified as neoplasm of uncertain or unknown behavior?	Yes	No
18. Please circle your reply to Question (a) to (g) below, if the patient's condition is skin cancer, please confirm its type based on the following:		
a. Is the patient's condition Carcinoma in situ of the skin (both melanoma & non-melanoma)?	Yes	No
b. Is the patient's condition malignant melanoma that has not invaded beyond the epidermis?	Yes	No
c. Is the patient's condition hyperkeratosis skin cancer?	Yes	No
d. Is the patient's condition basal cell skin cancer?	Yes	No
e. Is the patient's condition squamous cell skin cancer?	Yes	No
f. Is the patient's condition skin confined primary cutaneous lymphoma or dermatofibrosarcoma protuberans?	Yes	No
g. Is the patient's condition invasive melanoma of less than 1.5mm Breslow thickness, or less than Clark Level 3?	Yes	No
If Yes to Question (g), please provide details of size, thickness and depth of invasion. Please also state if there is any pathologic evidence of invasion beyond the epidermis or metastases to lymph nodes.		
19. Is the patient's condition prostate cancers histologically described as T1N0M0? Please circle.	Yes	No
If Yes, please circle the exact stage T1 classification.	**T1a / T1b / T1c**	
20. Is the patient's condition thyroid cancer histologically described as T1N0M0? Please circle.	Yes	No
If Yes, please state the size in diameter:		
21. Is the patient's condition urinary bladder cancer histologically described as T1N0M0? Please circle.	Yes	No
22. Is the patient's condition non-invasive papillary urothelial carcinoma of the bladder (stage Ta)? Please circle.	Yes	No

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

23. Is the patient's condition papillary micro-carcinoma of the bladder? Please circle.	Yes	No
If Yes, please explain the medical justification to establish the diagnosis of papillary micro-carcinoma of the bladder:		
24. Is the patient's condition Gastro-Intestinal Stromal tumors (GIST) with mitotic count of less than or equal to 5/50 HPFs or histologically classified as Stage 1 or 1A according to the latest edition of the AJCC Cancer Staging Manual? Please circle.	Yes	No
If No, please state the tumour TNM classification and its mitotic count in HPFs:		
25. Is the patient's condition Chronic Lymphocytic Leukaemia less than RAI Stage 3? Please circle.	Yes	No
If No, please state the type of leukaemia and its RAI staging.		
26. Is the tumor a neuroendocrine tumor histologically classified as T1N0M0 (TMN classification)?	Yes	No
27. Is the tumor a neuroendocrine tumor histologically classified as below T1N0M0 (TMN classification)?	Yes	No
If No, please state the type of tumor and its staging.		
28. Is the tumor a pituitary neuroendocrine tumours (PitNET)?	Yes	No
a. Is the PitNet a Metastatic PitNET?	Yes	No
b. Is the PitNet a Pituitary Carcinoma?	Yes	No
29. Is the tumor carcinoma in situ of the biliary system (both intrahepatic and extrahepatic)?	Yes	No
30. Is the patient's condition a bone marrow malignancy which does not require recurrent blood transfusions, chemotherapy, targeted cancer therapies, bone marrow transplant, hematopoietic stem cell transplant or other major interventionist treatment?	Yes	No
31. Is the tumor in the presence of HIV infection? Please circle.	Yes	No
If Yes, please indicate patient's status of patient's HIV infection and date when he/she was diagnosed with HIV infection:		

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

32. Please provide details of all investigations / test performed.
Please enclose copies of all reports including biopsy, reports, cytology reports, X-rays, CT scans, other imaging studies, laboratory evidence, surgical reports, etc. and any relevant hospital reports that are available.

33. Please provide details of the cancer treatment provided to the patient:

Treatment	Type of treatment / Name of surgery	Date of treatment / surgery (DD/MM/YYYY)
a. Chemotherapy		
b. Radiotherapy		
c. Radiation Surgery or Radiosurgery		
d. Targeted Therapy		
e. Immunotherapy		
f. Radical Surgery *(refers to total and complete removal of the organ affected by cancer along with removal of blood supply, lymph nodes and the adjacent tissues that could contain cancer)*		
g. Others, please specify:		

34. Is the cancer treatment for preventive purposes, such as hormonal therapy (including but not limited to Tamoxifen or Raloxifen)?	Yes	No

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

Part II

35. Did the patient undergo any surgery? Please circle. If Yes, please provide the following details and a copy of the operation report.	Yes	No

Date of surgery (DD/MM/YYYY)	Name of surgery	Was surgery performed for total or partial organ removal?	Reason for performing the surgery.

36. If mastectomy was performed due to a diagnosis of invasive breast cancer, please state if reconstructive surgery was done? Please circle.	Yes	No

If Yes, please state date of breast reconstructive surgery. (DD/MM/YYYY)	If No and patient was recommended for reconstructive surgery, please state date of planned surgery. (DD/MM/YYYY)

37. Did the patient undergo any other type of non-surgical treatment option? (e.g. chemotherapy, radiotherapy, etc.) Please circle. If Yes, please provide the following details.	Yes	No

Date of treatment (DD/MM/YYYY)	Type of treatment	Patient's response to treatment

38. Does patient's condition require a major organ or bone marrow transplant? Please circle. If Yes, please provide the following details:	Yes	No
a. For major organ transplant, was the transplant resulted from an irreversible end stage failure of the relevant organ? Please circle.	Yes	No

Which organ is involved?	Date of transplantation	Prognosis of patient's condition
	(DD/MM/YYYY)	

b. For bone marrow transplant, is the receipt of transplant from human bone marrow using haematopoietic stem cells preceded by total bone marrow ablation? Please circle.	Yes	No

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

Part III		
39. 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? Please circle.	Yes	No
40. In your opinion, is patient's condition highly likely to lead to death within the next 12 months? Please circle.	Yes	No
If Yes, what is your reason of your evaluation?		
41. Please circle your reply to Question (a) to (d) below, if patient's condition or surgery performed in any way related to 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

If Yes to any of Question (a) to (d), please provide the following in detail and to provide a copy of the investigation test result:

Exact diagnosis	**Date of diagnosis (DD/MM/YYYY)**	**Name and address of treating doctor**

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

42. Has the patient previously suffered from cancer, tumor, cyst or growth of any kind, or enlarged nodes? If Yes, please provide the following details:				Yes	No
Diagnosis	**Date of diagnosis (DD/MM/YYYY)**	**Date when patient was informed of diagnosis**	**Name and date of treatments**	**Name and address of treating doctor**	

43. Is there anything in patient's medical history which would have increased the risk of having cancers? If Yes, please provide the following details:				Yes	No
Diagnosis	**Date of diagnosis (DD/MM/YYYY)**	**Date when patient was informed of diagnosis**	**Name and date of treatments**	**Name and address of treating doctor**	

44. 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/YYYY)**	**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	

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. Histopathological / Biopsy reports
2. Operation reports (if surgery has been performed)