CRISIS COVER CLAIM FORM

ADDITIONAL CRITICAL ILLNESS & MEDICAL CONDITION

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. Prudential Assurance Company Singapore (Pte) Limited ("**PACS**") 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.

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

☐	Accidental fracture of spinal column	☐	Acute Necrohaemorrhagic pancreatitis	☐	Addison disease or autoimmune adrenalitis
☐	Adrenalectomy for adrenal adenoma	☐	Biliary atresia having undergone liver transplantation	☐	Chronic auto-immune hepatitis
☐	Creutzfeld-Jakob disease	☐	Ebola	☐	Elephantiasis
☐	Full-blown AIDS	☐	Idiopathic pulmonary fibrosis	☐	Infective endocarditis
☐	Juvenile Huntington disease	☐	Medically acquired HIV	☐	Medullary cystic disease
☐	Meningeal tuberculosis	☐	Multiple root avulsions of brachial plexus	☐	Necrotising fasciitis
☐	Occupationally acquired Hepatitis B or C	☐	Pheochromocytoma	☐	Progressive supranuclear palsy
☐	Resection of the whole small intestine (duodenum, jejunum and ileum)	☐	Severe cardiomyopathy	☐	Severe Crohn's disease
☐	Severe Eisenmenger's syndrome	☐	Severe myasthenia gravis	☐	Severe ulcerative colitis
☐	Surgery for idiopathic scoliosis				

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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. If the claim is on Medically Acquired Aids, please provide details to the questions below:

a. Did the medical institution responsible for the procedure either admit liability for the infection; or is found liable by a final court judgment that is not subject to further appeal?	Yes	No
b. If yes, please provide a copy of the evidence.		

6. 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:
- the name of police officer and police station at which the accident was reported; and
- a copy of the police report.

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

If yes, please give details.

8. 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

9. 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

10. 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

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 policyowner 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

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

PART II - MEDICAL SPECIALIST REPORT
ADDITIONAL CRITICAL ILLNESS & MEDICAL CONDITION
(To be completed by the Life Assured's attending medical specialist)

Please circle the appropriate illness/disease/condition in the table and complete the relevant sections in respect to the illness/disease/condition claims. **Please submit ONLY the relevant sections to us upon completion.**

S/N	Critical Illness	Sections to be completed
1	Accidental fracture of spinal column	1, 2, 29
2	Acute Necrohaemorrhagic pancreatitis	1, 3, 29
3	Addison disease or autoimmune adrenalitis	1, 4, 29
4	Adrenalectomy for adrenal adenoma	1, 5, 29
5	Biliary atresia having undergone liver transplantation	1, 6, 29
6	Creutzfeld-Jacob disease	1, 7, 29
7	Chronic auto-immune hepatitis	1, 8, 29
8	Ebola	1, 9, 29
9	Elephantiasis	1, 10, 29
10	Full-blown AIDS	1, 11, 29
11	Idiopathic pulmonary fibrosis	1, 12, 29
12	Infective endocarditis	1, 13, 29
13	Juvenile Huntington Disease	1, 14, 29
14	Medically acquired HIV	1, 15, 29
15	Medullary cystic disease	1, 16, 29
16	Meningeal tuberculosis	1, 17, 29
17	Multiple root avulsions of brachial plexus	1, 18, 29
18	Necrotising fasciitis	1, 19, 29
19	Occupationally Acquired Hepatitis B or C	1, 20, 29
20	Pheochromocytoma	1, 21, 29
21	Progressive supranuclear palsy	1, 22, 29
22	Resection of the whole small intestine (duodenum, jejunum and ileum)	1, 23, 29
23	Severe Crohn's disease	1, 24, 29
24	Severe Eisenmenger's syndrome	1, 25, 29
25	Surgery for idiopathic scoliosis	1, 26, 29
26	Severe ulcerative colitis	1, 27, 29
27	Severe myasthenia gravis	1, 28, 29

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

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

SECTION 1 : GENERAL INFORMATION						
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 first informed of the diagnosis.		DD		MM		YYYY
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?		Yes	No
11. If Yes, 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 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		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.						

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

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

SECTION 2 : ACCIDENTAL FRACTURE OF SPINAL COLUMN		
1. Was the patient diagnosed with new multiple spinal fracture?	Yes	No
2. Was the multiple spinal fracture caused by an Accident?	Yes	No
3. Date of Accident	(DD/MM/YYYY)	
4. Date patient diagnosed with new multiple spinal fracture	(DD/MM/YYYY)	
5. Did the Accident results in a total and permanent neurological deficit with persisting clinical symptoms?	Yes	No
a) If yes, please state what are the permanent neurological deficits suffered by the patient		
b) Please provide a copy of the X-ray or other imaging technology		
6. Did patient suffer from inability to perform (whether aided or unaided) of at least 2 of the 6 Activities of Daily Living for a continuous period of at least 6 months?	Yes	No

7. Please advise if the injury has resulted in the patient's inability to perform the Activities of Daily Living.

ADLs	Is the patient able to perform the ADL independently?	When did the patient became unable to perform such ADLs?	Is the inability to perform the ADL permanent?
Washing			
Dressing			
Transferring			
Mobility			
Toileting			
Feeding			

SECTION 3 : ACUTE NECROHAEMORRHAGIC PANCREATITIS		
1. Did the patient undergo any surgical clearance of necrotic tissue or pancreatectomy?	Yes	No
2. If yes, please state the nature of the surgery performed. Please also provide a copy of the operation report.		
3. Date the surgery was performed	(DD/MM/YYYY)	
4. Was the diagnosis of Acute Necrohaemorrhagic pancreatitis confirmed on histological evidence?	Yes	No
Please provide a copy of the histology report.		
5. Was the cause of the pancreatitis due to alcohol or drug abuse?	Yes	No
If yes, please provide details.		
Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date	

SECTION 4 : ADDISON DISEASE OR AUTOIMMUNE ADRENALITIS		
1. Was the adrenocortical insufficiency due to the destruction or dysfunction of the entire adrenal cortex?	Yes	No
a. Was there raised of blood ACTH greater than 50pg/ml?	Yes	No
b. Was there evidence of no response of raised aldosterone (serum cortisone) with ACTH test?	Yes	No
c. Was there a need for lifelong glucocorticoid and mineral corticoid replacement therapy?	Yes	No
2a. What is the cause of adrenal insufficiency?		
2b. Was the cause of adrenal insufficiency due to autoimmune cause?	Yes	No
SECTION 5 : ADRENALECTOMY FOR ADRENAL ADENOMA		
1. Was the adrenalectomy performed for treatment of malignant systemic hypertension?	Yes	No
2. Was the malignant systemic hypertension secondary to an aldosterone secreting adrenal adenoma?	Yes	No
3. Was the malignant hypertension able to be controlled by medical therapy?	Yes	No
4. If yes, please state the medical therapy prescribed.		
SECTION 6 : BILIARY ATRESIA HAVING UNDERGONE LIVER TRANSPLANTATION		
1. Was patient's Biliary Atresia condition progressive, disease of the extra-hepatic biliary tree?	Yes	No
2. Was patient's Biliary Atresia condition idiopathic disease of the extra-hepatic biliary tree?	Yes	No
3. Was patient's Biliary Atresia condition fibro-obliterative disease of the extra-hepatic biliary tree?	Yes	No
4. Did patient's Biliary Atresia condition present with Biliary Obstruction?	Yes	No
5. Did patient undergo liver transplantation?	Yes	No
6. If yes, please advise the date the surgery was performed	(DD/MM/YYYY)	
7. Was patient on a registered liver transplantation waiting list?	Yes	No
8. Was patient's Biliary Atresia condition due to other diseases?	Yes	No
9. Please provide a copy of supporting evidence including imaging, laboratory tests and liver biopsy.		

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

SECTION 7 : CREUTZFELD-JACOB DISEASE		
1. Has the patient's condition resulted in an associated neurological deficit?	Yes	No
2. Please describe the neurological deficit.		
3. Is the neurological deficit permanent?	Yes	No
4. Please advise if the deficit has resulted in the patient's inability to perform the Activities of Daily Living.		

ADLs	Is the patient able to perform the ADL independently?	When did the patient become unable to perform such ADLs?	Is the inability to perform the ADL permanent?
Washing			
Dressing			
Transferring			
Mobility			
Toileting			
Feeding			

5. Was the disease caused by human growth hormone treatment?	Yes	No
SECTION 8 : CHRONIC AUTO-IMMUNE HEPATITIS		
1. Is there presence of hypergammaglobulinaemia?	Yes	No
2. Is there presence of any of the following auto-antibodies?		
- Anti-nuclear antibody (ANA)	Yes	No
- Anti-smooth muscle antibodies	Yes	No
- Anti-actin antibodies	Yes	No
- Antibodies to Liver-Kidney Microsome (Anti-LKM-1)	Yes	No
- Anti- LC1 antibodies	Yes	No
- Anti-SLA/ LP antibodies	Yes	No
3. Please advise if a liver biopsy was performed	Yes	No
If yes, please provide us with a copy of the liver biopsy results confirming the diagnosis of Chronic auto-immune hepatitis.		
SECTION 9 : EBOLA		
1. Was the patient infected with the Ebola virus?	Yes	No
2. Was the presence of the virus confirmed by laboratory testing?	Yes	No
Please provide us with a copy if the laboratory test results confirming the presence of the Ebola virus		
3. Were there evidence of ongoing complications of the infection persisting more than 30 days from the onset of the symptoms?	Yes	No
4. Did the infection resulted in death of the patient	Yes	No
5. Was there any effective cure for the virus	Yes	No
Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date	

SECTION 10 : ELEPHANTIASIS		
1. Was there an unequivocal diagnosis of Elephantiasis?	Yes	No
2. Was the diagnosis supported by laboratory confirmation of microfilariae	Yes	No
3. Was there lymphedema caused any of the following:		
- infection with other disease(s)	Yes	No
- trauma, post-operative scarring	Yes	No
- congestive heart failure	Yes	No
- congenital lymphatic system abnormalities	Yes	No
SECTION 11 : FULL-BLOWN AIDS		
1. Was the diagnosis of AIDS (Acquired Immuno-deficiency Syndrome) confirmed on HIV (Human Immuno-deficiency Virus) antibody test and confirmatory test?	Yes	No
Please provide a copy of the HIV (Human Immuno-deficiency Virus) antibody and confirmatory tests.		
2. Does the patient have a CD4 cell count of less than two hundred (200)/μL?	Yes	No
3. Does the patient's condition meet any of the following criteria:		
- Weight loss of more than ten percent (10%) of body weight over a period of six (6) months or less (wasting syndrome)	Yes	No
- Kaposi Sarcoma	Yes	No
- Pneumocystis Carinii Pneumonia	Yes	No
- Progressive multifocal leukoencephalopathy	Yes	No
- Active Tuberculosis	Yes	No
- Less than one-thousand (1000) Lymphocytes/μL	Yes	No
- Malignant Lymphoma	Yes	No
SECTION 12 : IDIOPATHIC PULMONARY FIBROSIS		
1. Does the patient require extensive and permanent oxygen therapy?	Yes	No
2. If yes, how many hours of oxygen therapy does he require per day? _____ (no. of hours)		
3. Is the patient's lung function consistently showing: - FVC ≤ 50%? - DLCO ≤ 35% of predicted value?	Yes Yes	No No
Please provide a copy of the patient's lung function results.		
4. Was the diagnosis of idiopathic pulmonary fibrosis confirmed on lung biopsy? Please provide us with a copy of the biopsy results.	Yes	No

SECTION 13 : INFECTIVE ENDOCARDITIS		
1. Was the patient's endocarditis caused by infective organisms?	Yes	No
2. Are there presence of any or all of the following:		
- positive result of the blood culture proving presence of the infectious organism?	Yes	No
- presence of at least moderate heart valve incompetence (meaning regurgitant fraction of 20% or above) or moderate heart valve stenosis (resulting in heart valve area of 30% or less of normal value) attributable to infective endocarditis?	Yes	No

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

3. Was the diagnosis of infective endocarditis and the severity of valvular impairment confirmed by a cardiologist?	Yes	No
SECTION 14 : JUVENILE HUNTINGTON DISEASE		
1. Was there movement disorder due to Juvenile Huntington Disease?	Yes	No
2. Was there cognitive disorder due to Juvenile Huntington Disease?	Yes	No
3. Was there behavior disorder due to Juvenile Huntington Disease?	Yes	No
4. Was the diagnosis of Juvenile Huntington Disease confirmed with genetic test evidence?	Yes	No
Please provide a copy of the genetic test.		
SECTION 15 : MEDICALLY ACQUIRED AIDS		
1. Was the infection resulted directly from a surgical, medical, or dental procedure performed in Singapore?	Yes	No
a. If yes, please state the date of the procedure performed. Please also provide a copy of the operation report.	(DD/MM/YYYY)	
2. Was the patient a hemophiliac?	Yes	No
3. Was the incident reported to the relevant authorities and investigated in accordance with established procedures?	Yes	No
If yes, please provide a copy of the report		
4. Was the HIV infection resulted from any other means, including but not limited to sexual activity or intravenous drug use?	Yes	No
SECTION 16 : MEDULLARY CYSTIC DISEASE		
1. Was there presence of multiple cysts in the renal medulla?	Yes	No
2. Was it accompanied by the presence of tubular atrophy and interstitial fibrosis?	Yes	No
3. Were there clinical manifestations of the following:		
- anaemia	Yes	No
- polyuria	Yes	No
- progressive deterioration in kidney function	Yes	No
4. Was the diagnosis of Medullary cystic function confirmed by renal biopsy?	Yes	No
Please provide us with a copy of the renal biopsy results.		
5. Does the patient have isolated or benign kidney cysts?	Yes	No
SECTION 17 : MENINGEAL TUBERCULOSIS		
1. Does the patient have meningitis caused by tubercle bacilli?	Yes	No
2. Did the condition result in permanent* neurological deficit?	Yes	No
If yes, please specify the neurological deficits suffered by the patient.		

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

3. Was the evidence of permanent* clinical neurological deficit confirmed at least 6 weeks after the diagnosis of Meningeal tuberculosis?	Yes	No
4. Were there findings of M. tuberculosis infection confirmed on cerebrospinal fluid by lumbar puncture and CSF culture?	Yes	No
**expected to last throughout the lifetime of the patient*		
SECTION 18 : MULTIPLE ROOT AVULSIONS OF BRACHIAL PLEXUS		
1. Does the patient suffer from complete and the permanent loss of use and sensory functions of an upper extremity	Yes	No
2. Was it caused by avulsion of 2 or more nerve roots of the brachia plexus?	Yes	No
3. Was the loss sustained through an accident or injury?	Yes	No
Please provide details of the accident or injury.		
4. Was the injury to the nerve roots confirmed by electrodiagnostic study	Yes	No
SECTION 19 : NECROTISING FASCIITIS		
1. Were the usual clinical criteria for necrotizing fasciitis met?	Yes	No
2. Was the bacterial identified a known cause of necrotizing fasciitis?	Yes	No
3. Were there widespread destruction of muscle and other soft tissues?	Yes	No
4. Did the widespread destruction result in a total and permanent loss of function in the affected body part?	Yes	No
Please specify the loss of function and the affected body part.		
SECTION 20: OCCUPATIONALLY ACQUIRED HEPATITIS B or C		
1. Was the patient infected with Hepatitis B or C from an accident whilst carrying out the normal professional duties of his or her occupation?	Yes	No
a. If yes, please state the date of the accident.	(DD/MM/YYYY)	
2. What is the patient's occupation?		
3. What duties were the patient carrying out when he/ she was infected with the virus?		
4. Was there proof that the accident involved a definite source of the hepatitis B or C infected fluids?	Yes	No
5. Was there a need for antiviral therapy as a consequence of proven seroconversion?	Yes	No
6. Was the Hepatitis B or C infection resulting from any other means including sexual activity and the use of intravenous drugs?	Yes	No
SECTION 21 : PHEOCHROMOCYTOMA		
1. Was the patient diagnosed to have Pheochromocytoma?	Yes	No
2. Did the patient undergo a surgical removal of the tumor?	Yes	No
3. Was the diagnosis of Pheochromocytoma made upon a histopathological examination?	Yes	No
Please provide us with a copy of the histology report confirming the diagnosis.		

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

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

SECTION 22: PROGRESSIVE SUPRANUCLEAR PALSY		
1. Was the occurrence of Progressive supranuclear palsy independent of all other causes?	Yes	No
2. Did it result in permanent neurological deficit?	Yes	No
If yes, please specify the neurological deficits suffered by the patient.		
3. Please advise if the deficit has resulted in the patient's inability to perform the Activities of Daily Living.		

ADLs	**Is the patient able to perform the ADL independently?**	**When did the patient become unable to perform such ADLs?**	**Is the inability to perform the ADL permanent?**
Washing			
Dressing			
Transferring			
Mobility			
Toileting			
Feeding			

SECTION 23: RESECTION OF THE WHOLE SMALL INTESTINE (DUODENUM, JEJUNUM and ILEUM)		
1. Does the patient undergo complete surgical removal of the whole small intestine including the duodenum, jejunum and ileum as a result of illness or an accident?	Yes	No
2. If yes, please state the nature of the surgery performed. Please also provide a copy of the operation report.		
3. Date the surgery was performed	(DD/MM/YYYY)	
4. Was the surgery a partial removal of small intestine?	Yes	No

SECTION 24 : SEVERE CROHN'S DISEASE		
1. Is there evidence of continued inflammation in spite of optimal therapy?	Yes	No
2. Is the patient's condition evidenced by any or all of the following:		
- Stricture formation causing intestinal obstruction requiring admission to hospital	Yes	No
- Fistula formation between loops of bowel	Yes	No
- At least one (1) bowel segment resection	Yes	No
3. Was the diagnosis of Crohn's disease confirmed on histological findings Please provide us with a copy of the histology report.	Yes	No

SECTION 25 : SEVERE EISENMENGER'S SYNDROME		
1. Was the reversed or bidirectional shunt caused by a result of pulmonary hypertension caused by a heart disorder?	Yes	No
2. Was the patient symptomatic during ordinary daily activities despite the use of medication and dietary adjustment?	Yes	No
3. Was there evidence of abnormal ventricular function on physical examination and laboratory studies?	Yes	No
Please provide us with a copy of the laboratory results.		
Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date	

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

4. Was there presence of permanent physical impairment classified as NYHA Class IV?	Yes	No
Please provide details of the NYHA classification in the table below:		

New York Heart Association functional classification	What is the limitation in physical activity patient has?	What is patient's NYHA classification for the current condition? Please tick accordingly.	Is this limitation of physical activity permanent? Please circle.	
Class I			Yes	No
Class II			Yes	No
Class III			Yes	No
Class IV			Yes	No

SECTION 26: SURGERY FOR IDIOPATHIC SCOLIOSIS

1. Is the patient suffering from scoliosis?	Yes	No
2. Was the curve of the spine more than cobb angle 40 degree?	Yes	No
3. Was there an identifiable underlying cause for the scoliosis?	Yes	No
If yes, please state the underlying cause.		
4. Was the spinal deformity associated with any congenital defects and neuromuscular diseases?	Yes	No
If yes, please provide details of the congenital defect and neuromuscular diseases.		
5. Has the patient undergone any spinal surgery to correct the abnormal curvature of the spine from its normal straight line viewed from the back?	Yes	No
If yes, please state the date of surgery and the nature of surgery performed. Date of surgery: _____ (DD/MM/YYYY) Nature of surgery: _____		

SECTION 27: SEVERE ULCERATIVE COLITIS

1. Was the patient diagnosed to have ulcerative colitis?	Yes	No
2. Did his/ her condition present with any of the following criteria:		
- The entire colon is affected with severe bloody diarrhea;	Yes	No
- He/ She was treated with total colectomy and ileostomy;	Yes	No
- The diagnosis was confirmed on histological features and confirmed by a gastroenterologist	Yes	No

SECTION 28: SEVERE MYASTHENIA GRAVIS

1. Is the patient suffering from myasthenia gravis?	Yes	No
2. Did his/ her condition present with permanent muscle weakness categorized as Class III, IV or V according to the Myasthenia Gravis Foundation of America Clinical Classification?	Yes	No
Myasthenia Gravis Foundation of America Clinical Classification: Class I - Any eye muscle weakness, possible ptosis, no other evidence of muscle weakness elsewhere Class II - Eye muscle weakness of any severity, mild weakness of other muscles Class III - Eye muscle weakness of any severity, moderate weakness of other muscles Class IV - Eye muscle weakness of any severity, severe weakness of other muscles Class V - Intubation needed to maintain airway		
3. Was the diagnosis confirmed by a neurologist?	Yes	No

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

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

SECTION 29: 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 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
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 YYYY	
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 the condition described above or any related illness? If Yes, please provide the details below:	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 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:	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.