

PruParent Benefit Claim Form

This form must 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

The issue of this form is in no way an admission of liability. No claim can be considered unless the medical examiner's report is furnished at the expense of the claimant.

Important Note: 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.

Required documents for claim submission:

1. PruParent Claim Form (all sections must be completed)
2. Clinical Abstract Application Form (3 copies)
3. PruParent Medical Report Form OR Long Term Care Benefit Assessment Report (please select the appropriate form depending on the benefit you are claiming against)
4. Diagnostic laboratory and objective test reports supporting the diagnosis

POLICY DETAILS

Please indicate the policy number for the benefit type you would like to claim.

LIFE ASSURED'S PARTICULARS

Full Name			NRIC No:	
Address			Postal Code	
Date of Birth (DD/MM/YYYY)		Contact No:		

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.**

☐ 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 bank book or bank statement is not submitted, or the details cannot be verified, payment will be made via **PayNow (NRIC/FIN)** by default.

1. TYPE OF CLAIM		
Type of Claim	Benefit Plan Type	
☐ Hospital Room and Board	☐ Plan 1	
☐ Surgical Procedure	☐ Plan 2	
☐ Long Term Care	☐ Plan 3	
	☐ Plan 4	
2. NATURE OF CLAIM		
2.1. What is the cause of illness / injury?		
☐ Illness Date symptoms first started (DD/MM/YYYY): _____		
☐ Accident Date of Accident (DD/MM/YYYY): _____ Time of Accident: _____		
2.2. Was there a police report?	Yes	No
If Yes, please provide a copy		
2.3. Period of hospitalisation (DD/MM/YYYY):		
From: _____ To: _____		
2.4. Date of surgical procedure (DD/MM/YYYY):		
2.5. Please describe in detail the nature of the illness / disability / injury. If the condition is caused by an accident, please provide details on how the accident happened.		
2.6. Please provide details on any surgical procedure performed.		
2.7. If you are claiming for Long Term Care benefit, please tick against the Activities of Daily Living that you are unable to perform independently for at least 3 months.		
☐ Transferring - Getting in and out of a chair on your own		
☐ Mobility - Move indoor from room to room on level surface		
☐ Continence - Control bowel and bladder functions voluntarily		
☐ Dressing - Putting on and taking off clothing on your own		
☐ Bathing / Washing - Wash yourself in the bath or shower		
☐ Eating - Eat and drink on your own		
2.8. Date on which you became unable to perform the Activities of Daily Living selected in Q2.7 (DD/MM/YYYY):		

2.9. Please provide the details of all doctors or specialists whom you have consulted in connection with your illness/injury: -

Name of Doctor	Name and Address of Clinic/ Hospital	Dates of Consultation	Reason for Visit

2.10. Please provide the details of all doctors or specialists whom you have consulted in connection with your illness/injury: -

Name of Doctor	Name and Address of Clinic/ Hospital

3. GENERAL

3.1. Are you insured for similar benefits with any other company? If Yes, please give full details:-

Name of Insurer	Type of Plan	Date of Issue	Benefit Amount

Name of Life Assured:	NRIC / Passport No. of Life Assured:
DECLARATION	
- 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 agree that if I have provided any false or fraudulent information, or suppressed, concealed and/or falsely stated any material facts with regard to this claim, the policy shall be void and all rights of recovery in respect of past or future claims shall be forfeited. - I 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. - I understand and agree that the submission of this form does not mean that my request will be processed, and that any payout under the policy shall be in PACS sole and absolute discretion. I further acknowledge and agree that the furnishing this form or other supplemental forms 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 or defences. - 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. - I acknowledge and accept that PACS expressly reserves its rights to require or obtain further information and documentation as it deems necessary. I acknowledge that I am solely responsible for the costs of providing such information and documentation as requested by PACS. - I confirmed 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). - I agree to produce all original document(s) that were submitted for reimbursement to PACS for verification as it deems necessary. - 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: - 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 - 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. - 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. - 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. - 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. - I agree to receive communication on the claim by email, SMS and/or hard copies by post. - 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 & Signature of Life Assured above age 18 years	Date & Signature of Policyowner
	Relationship to Life Assured