Reg. No 199002477Z

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

LIFE ASSURED'S PARTICULARS

Full Name _____ NRIC No _____

Address _____

Date of Birth _____ Contact No _____ Occupation _____

Method of Delivery for Claim Settlement:

☐ Mail ☐ Self Collection ☐ Delivery by a Prudential Financial Consultant

POLICY DETAILS

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

_____

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: _____

☐ **Accident**
Date and Time of Accident: _____

2.2 Was there a police report? ☐ Yes ☐ No

(If yes, please provide a copy)

2.3. Period of hospitalisation: _____ to _____

2.4. Date of surgical procedure: _____

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(a). 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 clothings on your own

☐ Bathing / Washing - Wash yourself in the bath or shower

☐ Eating - Eat and drink on your own

2.7(b). Date on which you became unable to perform the Activities of Daily Living selected in Q2.7(a).

2.8 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

2.9 Please provide details of your usual medical attendant if different from above: -

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

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 ("**Prudential**") 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 Prudential, 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 Prudential 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 Prudential 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 Prudential 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 Prudential under this Policy, (iii) storage and retention, (iv) meeting requirements of prevailing internal policies of Prudential, and (v) as set out in Prudential's 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 Prudential, its officers, employees, representatives or distribution partners, 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, its officers, employees, representatives or distribution partners 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, Prudential'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 Prudential, 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 Prudential's Privacy Notice.

10. I agree to indemnify Prudential for all losses and damages that Prudential, its officers, employees, representatives or distribution partners may suffer in the event that I am in breach of any representation and warranty provided to me herein.

11. I agree to receive communication on the claim by email, SMS and/or hard copies by post.

12. 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

Name of Policyowner	NRIC / Passport No. of Policyowner	Relationship to Life Assured