DISABILITY CLAIM FORM

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.

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

Please tick the appropriate box for the benefit(s) you are claiming.

☐ Total and Permanent Disability ☐ Early Stage Disability

DETAILS OF OCCUPATION / ACTIVITIES OF DAILY LIVINGS (ADLs)

	Before disability	After disability
Occupation		
Exact nature of occupational duties If the Life Assured is not working, please provide a list of the daily activities.		
Name and address of business and employer		

C010519

Monthly income		
Date you last worked		
Date you returned to work / Expected date of return * (*delete where appropriate)		

DETAILS OF DISABILITY

Please complete Question 1 to 5 if disability was DUE TO ACCIDENT

1. Date of accident		DD		MM		YY
2. Time of accident	HR		MIN		Please circle AM	PM

3. Describe fully where and how did the accident happen?

4. Describe the type and extent of injury.

5. Was the accident reported to the Police? Please circle.	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 in this claim submission.

Please complete Question 6 to 9 if disability was DUE TO ILLNESS

6. Describe fully the signs or symptoms for which doctor was consulted and/or received treatment.

7. Date when signs or symptoms first started		DD		MM		YY
8. Date when Life Assured first consulted a doctor for above signs or symptoms.		DD		MM		YY

9. Name and address of doctor(s) consulted.

Please complete Question 10 if claim was filed on EARLY DISABILITY BENEFIT

10. If the claim was on Early Stage Disability, please indicate the Quality of Life Conditions that you are claiming for.

Please tick	Quality of Life Conditions	Date disability started (dd/mm/yy)
	Walking – The inability to walk more than 200m on a level surface continuously with or without aids and adaptations, within 5 minutes, because of breathlessness or severe pain.	
	Fine Hand Control – The inability to remove 5 paracetamol pills from a blister pack within 60 seconds, using your hand(s) with or without aids and adaptations.	
	Sitting and Rising from a chair – The inability to sit and rise to a standing position from a wheelchair or chair (both with arms) of 40cm to 45cm in height without the help of another person.	
	Lifting and carrying – The inability to lift (from a bench with a height of 1m) and carry a 2kg weight for 10m and then placing it back down at bench height, with or without aids and adaptations.	
	Communicating – As a result of an illness or injury, the inability to hear sounds of below 60 decibels in all frequencies of hearing or the inability to speak with sufficient clarity.	
	Eyesight – When tested with visual aids, vision is measured at 6/60 or worse in one of the eyes using a Snellen eye chart.	

DETAILS OF CONSULTATION / HOSPITALIZATION

11. Please provide the details of doctor or specialist whom Life Assured has consulted in connection with his/her illness/injury :-

Name of Doctor/Specialist	Name and Address of Clinic/Hospital	Date of Consultations	Reason(s) for Consultation

12. 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/Specialist	Name and Address of Clinic/Hospital	Date of Consultations	Reason(s) for Consultation

OTHER INSURANCE

13. 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

14. 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

TOTAL AND PERMANENT DISABILITY / EARLY DISABILITY

(To be completed by 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		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
If the date is unknown, please state how long the symptoms had been present prior to the date of first consultation.						
5. What were your clinical and physical/mental findings when you first saw patient?						
6. Please provide exact diagnosis :						
7. What is /are the underlying cause(s)?						

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

8. Date of diagnosis.		DD		MM		YY
9. Date the patient / patient's next of kin was informed of the diagnosis.		DD		MM		YY

10. What was the exact information regarding diagnosis that patient or patient's next-of-kin was informed of?

11. Please provide the details of patient's treatments (including any investigations/surgery administered) and his/her response to these treatments in chronological order. To **enclose copies** of the reports.

Date of treatment (dd/mm/yy)	Details of treatment	Investigation/Surgery	Patient's treatment progress

12. Please provide details of the medications prescribed and if any medicines have been titrated since the initial onset of disability.

13. Were you the doctor who **first** diagnosed the patient with this condition? Please circle.		Yes	No
14. If Yes, over what period do your records extend?	From (dd/mm/yy)	To (dd/mm/yy)	

15. 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 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?		DD		MM		YY

d. What was the reason for referral to see you? Please attach a copy of the referral letter.

e. Please provide name and practice address of referral doctor.

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

PART II						
1. Date of last consultation		DD		MM		YY

2. What were the symptoms and complaints reported by patient during the last consultation?

3. What were your clinical and physical/mental findings when you last saw patient?

4. Based on the last consultation assessment of patient's disability, please describe the nature and severity of patient's physical/mental impairment in respect of this illness or injury.

5. As a result of the illness or injury, please state if patient's physical/mental impairment (as described in Question 4 above) had led to any of the following confinement requiring constant care and medical attention.

Type of Confinement	**Please circle**		**Period of Confinement**	
			From(dd/mm/yy)	**To (dd/mm/yy)**
a. Home (Please specify)	Yes	No		
b. Hospital (Please specify)	Yes	No		
c. Bed	Yes	No		
d. Wheelchair	Yes	No		
e. Others (Please specify)	Yes	No		

6. Is the patient able to perform (whether aided or unaided) the following Activities of Daily Living:

Activity	**Please circle if the patient can perform the listed activity?**		**Period of inability to perform**	
			From (dd/mm/yy)	**To (dd/mm/yy)**
Washing or bathing Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means. e.g. to wash the back, to wash hair	Yes	No		
Dressing Ability to put on, take off, secure and unfasten all garments (upper and lower) and, as appropriate, any braces, artificial limbs or other surgical or medical appliances. e.g. to button clothes, to put on trousers	Yes	No		

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

Activity	Please circle if the patient can perform the listed activity?		Period of inability to perform	
			From (dd/mm/yy)	To (dd/mm/yy)
Feeding Ability to feed oneself food after it has been prepared and made available. e.g. to scoop food, to put food into mouth	Yes	No		
Toileting Ability to use the lavatory or manage bowel and bladder functions through the use of protective undergarments or surgical appliances if appropriate. e.g. to get on or off the toilet	Yes	No		
Transferring Ability to move from a lying position on the bed to an upright chair or wheelchair, and vice versa. e.g. to be lifted up from lying position to sitting position from bed	Yes	No		
Mobility Ability to move indoors from room to room on level surfaces. e.g. to be supervised by someone closely in case of fall	Yes	No		

7. Please evaluate patient's level of functional ability based on the date of last consultation.

Activity	Date of evaluation (dd/mm/yy)	Please circle if the patient can perform the activity?		Date from which help was required (dd/mm/yy)	Please provide details.
Walking Walk more than 200m on a level surface continuously within 5 minutes, without having to stop because of breathlessness or severe pain.		Yes	No		
Fine Hand Control To remove 5 paracetamol pills from a blister pack within 60 seconds using your hand(s).		Yes	No		
Siting and Rising from a chair To sit and rise to a standing position from a wheelchair or chair (both with arms) of 40cm to 45cm in height.		Yes	No		
Lifting and Carrying To lift (from a bench with a height of 1 metre) and carry a 2kg weight for 10m and then placing it back down at bench height.		Yes	No		
Communicating To hear sounds of below 60 decibels in all frequencies of hearing or the ability to speak with sufficient clarity. Please attach ENT report.		Yes	No		
Eyesight Vision is measured at 6/60 or worse in one of the eyes using a Snellen eye chart, when tested with visual aids. Please attach Opthalmologist report.		Yes	No		

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

8. To the best of your knowledge and Hospital records, what is the occupation and nature of duties reported by patient before he/she suffered the physical/mental incapacity?		
9. To what extent does his/her physical/mental incapacity prevent him/her from performing all the normal duties of his/her usual occupation?		
10. If he/she cannot return to his/her usual occupation, can he/she engage in any other types of occupation?	Yes	No
a. If Yes, please provide details for the following :-	b. If No, please provide details for the following	
i. When do you think the patient will be able to return to work, either part-time or full-time?	i. Give details on any social, domestic or employment issues that are, or have been, impacting the patient's ability to work?	
ii. What are the types of occupation he/she can engage in?	ii. Please describe how the physical/mental impairments prevent the patient from ever continuing in any occupation, business or activity which pays him/her an income.	
11. Is the patient suffering from total loss of hearing in both the ears? Please circle.	Yes	No
a. Please provide the actual readings on the extent of hearing loss for both ears. Please provide **copies of audiogram and sound-threshold tests**.		
Left ear loss of hearing**:** decibels	Right ear loss of hearing**:** decibels	
b. Is the hearing loss irreversible? Please circle.	Yes	No
12. Is the patient suffering from total loss of ability to speak? Please circle.	Yes	No
a. Is the loss of ability to speak as a result of injury or disease to the vocal cord? Please circle.	Yes	No
b. Is the loss of ability to speak total and irrecoverable? Please circle.	Yes	No
c. Did the inability to speak last for a continuous period of 12 months? Please circle.	Yes	No
d. Please state the period of inability to speak.	From (dd/mm/yy)	To (dd/mm/yy)
e. Is the loss of ability to speak associated with any psychiatric condition? Please circle	Yes	No

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

13. Is the patient suffering from total and irrecoverable loss of use of both eyes? Please circle.	Yes	No
Please explain in details.		
14. Is the patient suffering from total and irrecoverable loss of use of any two limbs, excluding hands and feet? Please circle.	Yes	No
Please explain in details.		
15. Is the patient suffering from total and irrecoverable loss of use of one eye and any one limb excluding hands and feet? Please circle.	Yes	No
Please explain in details.		
16. In accordance to the Singapore's Mental Capacity Act (Cap 177A), is the patient mentally incapacitated? Please circle.	Yes	No

PART III

1. Is the patient's disability arising directly or indirectly out of:	Please circle.	
a. attempted suicide or self-inflicted injuries?	Yes	No
b. AIDS, AIDS-related complex or infection by HIV?	Yes	No
c. congenital or hereditary diseases or disorder?	Yes	No
d. mental and personality disorders (excluding Dementia and Alzheimer's disease)?	Yes	No
e. improper use of alcohol, alcohol abuse or alcohol dependence?	Yes	No

If you have answered Yes to any of the above Question 1(a) to 1(e), please provide details:

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

2. Has the patient previously consulted you or any other doctor for treatment or advice for this disability condition or any related condition? If yes, please provide the following details:	Yes	No

Diagnosis	Date of diagnosis (dd/mm/yy)	Date when patient was informed of diagnosis	Name and date of treatments	Name and address of treating doctor

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

3. Does the patient have or ever had any other significant health condition? If Yes, please provide 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 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.

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