ACCIDENT CLAIM FORM /PRUFRACTURE CARE CLAIM FORM/ HOSPITALISATION CLAIM FORM

Important Note

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. If the claim approved, all the payment cheque will be mailed to the policy owner

SECTION 1 (This section is 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.)

LIFE ASSURED'S PARTICULARS			
Full Name		NRIC No.	
Address		Postal Code	
Date of birth		Contact No.	

POLICY NUMBER (Please indicate the policy number for the benefit(s) you would like to claim)

TYPE OF CLAIM

Mandatory documents for claim submission

- ACCIDENT CLAIM FORM /PRUFRACTURE CARE CLAIM FORM/ HOSPITALISATION CLAIM FORM

	Claim Type (Please tick the appropriate box for the benefit type you are claiming)	**Additional Documents to be submitted together with the mandatory documents.**
☐	**Accidental Dismemberment / Permanent Disablement**	• Newspaper article (if available) • Police Report (if available) • Letter from your employer (If accident happened at work place)
☐	**Medical Reimbursement/Traditional Chinese Medicine** (Applicable for Millennium Comprehensive Personal Accident Benefit, Comprehensive Personal Accident Benefit, PRUPersonal Accident and Accident Assist Benefit) If there is a successful claim under this benefit within a policy year during the first 5 years of PruPersonal Accident Policy or Accident Assist Benefit, the Step-up Sum Assured feature of the PruPersonal Accident policy or Accident Assist Benefit stops and no further addition to the ADD sum assured will be made.	• Original final hospital / medical bills & receipts
☐	**Weekly Income / Temporary Disablement** **(**Applicable for Personal Accident Benefit, Millennium Comprehensive Personal Accident Benefit and Comprehensive Personal Accident Benefit)	• A copy of the Medical Certificates (MC)
☐	**Weekly Hospital / Hospital Cash / Medical Cash** (Applicable for Weekly Hospital Benefit/Hospital Cash/Medical Cash Benefit/ PruMedical Cash Benefit)	• A copy of the final hospital bills show admission and discharge date

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Claim Type (Please tick the appropriate box for the benefit type you are claiming)		Additional Documents to be submitted together with the mandatory required documents.
☐	**Daily Accidental Hospital Income/ICU** (Applicable for Recovery Aid Benefit of PruPersonal Accident and Accident Assist Benefit)	• A copy of the final hospital bills show admission and discharge date
☐	**Mobility Aid** (Applicable for Fracture Care PA Benefit, Recovery Aid Benefit of PruPersonal Accident and Accident Assist Benefit)	• Written Prescription for purchase of mobility aid • Original medical bills & receipts
☐	**Get Well Transport** (Applicable for Recovery Aid Benefit of PruPersonal Accident and Accident Assist Benefit)	• Original transportation bill & receipt
☐	**Fractures/Dislocations/Burns** (Applicable for Fracture Care PA Benefit)	• A copy of the x-ray report for Fracture and Dislocation. • A copy of Burn report for Burns
☐	**House Fitting Benefit** (Applicable for Fracture Care PA Benefit)	• Written Prescription for purchase of mobility aid • Original tax invoices
☐	**Recovery Benefit** (Applicable for Fracture Care PA Benefit)	• A copy of the final hospital / medical bills

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

1. Details of Illness							
1.1. Describe fully the extent and nature of illness.							
1.2. Date symptoms first started		DD		MM		YY	
1.3. Date first treated		DD		MM		YY	
1.4. Is the illness still being treated? (Please circle)					Yes	No	
1.4.1. If YES, please state nature of ongoing treatment and approximate date of completion.							
1.4.2. If NO, please state date of last treatment or appointment.							
1.5. Has the illness been treated previously? (Please circle)					Yes	No	
1.5.1. If YES, please state date of previous treatment.		DD		MM		YY	
1.5.2. Please state name and address of attending doctor for previous treatment.							
2. Details of Accident							
2.1. Date of Accident		DD		MM		YY	
2.2. Time of Accident							
2.3. Place of Accident							
2.4. Describe in detail how the accident happened. (Please enclose a copy of the police report, if any)							
2.5. Please state in detail the injuries sustained.							

2.6. Please state the date of first consultation. Please provide details of doctor(s) or hospital (s) consulted for this injuries.

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

2.7. Please state the reason if you did not seek treatment immediately after the accident.		
2.8 Was there a police report? If yes, please provide a copy (Please circle)	Yes	No

3. Other Information			
3.1. Date of hospitalisation	From (dd/mm/yy)	To (dd/mm/yy)	
3.2. Date of medical leave	From (dd/mm/yy)	To (dd/mm/yy)	
3.3. Was surgery performed? If YES, please provide details below. (Please circle)		Yes	No

Surgical Operation / Procedure	Date(s) of Operation / Procedure (dd/mm/yy)	Name & Address of Doctor(s) / Hospital(s)

3.4. Are you claiming Medical Expenses from other sources? If YES, please provide details below. (Please circle)	Yes	No

Name of Insurance Company, Employer, Third Party etc.	Nature of Claim	Amount Claimed	Policy Number (if applicable)

3.5. Please provide details of doctor(s) or hospital(s) admitted for this disability.

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

3.6. Please provide details of doctor(s) you consulted for any disorder on or before this hospitalisation.

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

Declaration

I declare that the above answers given by me in this form are true and complete and that no material information has been withheld or any relevant circumstances omitted.

Name & Signature of Life Assured if above 18 years old	Name & Signature of Policyowner(s)
Date	Date

SECTION 2 MEDICAL SPECIALIST REPORT

This section is to be completed by the life assured's attending medical specialist.

Name of Specialist		MCR No.
Field of Specialty		
Name of Medical Institution		
Name of Patient		NRIC No.
Patient's Occupation		

Details of Illness / Accident

1. Please circle the conditions to which this medical report relates.	Illness	Accident

2. Was patient admitted to a hospital? Please circle. If Yes, please provide the details below.	Yes	No

2.1 Name of hospital patient was admitted to	
2.2 Date and time of admission	
2.3 Date and time of discharge	

2.4 Please indicate how the patient was admitted. (Please circle).	Emergency admission	Doctor referral

a) If admission is via a doctor referral, please provide name & address of the referring doctor.

b) Please state the clinical basis for the referral and to enclose a copy of the referral letter.

2.5 Was surgery performed for this condition? (Please circle). If Yes, please provide details below.	Yes	No

Surgical Operation / Procedure	Date(s) of Operation / Procedure (dd/mm/yy)

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

2.6 What is the period of medical leave issued?	From (dd/mm/yy)	To (dd/mm/yy)

a) Please state the basis of medical leave granted

b) If further medical leave will be required after this end date, please state the reason.

2.7 What is the usual period of recovery for an injury of this severity?

2.8 When is the patient expected to recover?

3. Date of diagnosis of illness / Date of Accident		DD		MM		YY

4. Cause of illness / Cause of injury

5. Details of diagnosis of the illness / Details of injury including nature and extent of injury

5.1 Was the patient informed of the diagnosis? (Please circle).	Yes			No		
If yes, please state date patient was informed.		DD		MM		YY

5.2 Were the injuries caused solely by the accident described above? (Please circle).	Yes	No
5.3 Were there any underlying illnesses/ conditions that attributed to the accident/ injury? (Please circle).	Yes	No

5.3.1 If yes, please provide full details of the condition (including the type of condition, date of diagnosis and how it attributed to the accident/ injury).

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

6 Has the patient previously consulted or been treated for the condition mentioned in Q5? (Please circle).					Yes		No
6.1 If Yes, please state the date of first consultation.		DD		MM		YY	
6.2 Please indicate approximate date from which the patient first noticed symptoms of condition.		DD		MM		YY	
6.3 In your view, if the condition existed before symptoms became apparent to the patient, please indicate when this condition began to develop.		DD		MM		YY	
6.4 Was patient informed of the diagnosis? (Please circle).					Yes		No
6.5 Date patient was informed of the diagnosis.		DD		MM		YY	
6.6 Please state name and practice address of the doctor whom the patient has consulted or received treatment for this condition							

7 *As a result of the comment injury, is there* **permanent and total loss of use** of the organ or limb? Please circle. If Yes, please provide details in the following sections where appropriate.		*Yes*	*No*
Description	Please tick in the box		Please elaborate
7.1 Sight: Permanent and total loss of	☐	a) Sight in both eyes	
	☐	b) Sight in one eye	
	☐	c) The lens of one eye	
	☐	d) All sight in one eye except perception of light	
Additional Comments:			
Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**		Date	

Description	Please tick in the box		Please elaborate
7.2 Speech and hearing : Permanent and total loss off	☐	a) Speech and hearing	
	☐	b) Speech	
	☐	c) All hearing in both ears	
	☐	d) All hearing in one ear	
	☐	e) Whole ear for both ears	
	☐	f) Whole ear for one ear	
7.3 Limbs: Loss of or Permanent and total loss of use of	☐	a) Two limbs	
	☐	b) One limb	
	☐	c) One limb and sight of one eye	
	☐	d) Two hands or two Feet	
	☐	e) One hand and one foot	
	☐	f) One hand or one foot	
7.4 Arm: Total and Irrecoverable loss of the effective use of	☐	a) Arm at shoulder	
	☐	b) Arm between shoulder and elbow	
	☐	c) Arm at elbow	
	☐	d) Arm between elbow and wrist	
7.5 Hand: Loss of or Permanent and total loss of use of	☐	a) Hand at Wrist	
	☐	b) Both hands at wrist	
	☐	c) Both thumbs and all fingers	
	☐	d) Four fingers and Thumb of right hand	
Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**			Date

Description	Please tick in the box		Please elaborate
	☐	e) Four fingers and Thumb of left hand	
	☐	f) Four fingers of right hand	
	☐	g) Four fingers of left hand	
	☐	h) Right Thumb (both phalanges)	
	☐	i) Right Thumb (one phalanx)	
	☐	j) Left Thumb (both phalanges)	
	☐	k) Left Thumb (one phalanx)	
	☐	l) Right Index finger (three phalanges)	
	☐	m) Right Index finger (two phalanges)	
	☐	n) Right Index finger (one phalange)	
	☐	o) Left Index finger (three phalanges)	
	☐	p) Left Index finger (two phalanges)	
	☐	q) Left Index finger (one phalanx)	
	☐	r) Right Middle finger (three phalanges)	
	☐	s) Right Middle finger (two phalanges)	
	☐	t) Right Middle finger (one phalanx)	
	☐	u) Left Middle finger (three phalanges)	
	☐	v) Left Middle finger (two phalanges)	
	☐	w) Left Middle finger (one phalanges)	
	☐	x) Right Ring finger (three phalanges)	
	☐	y) Right Ring finger (two phalanges)	
Signature & Practice Stamp of the Medical Specialist who filled up **Section**			Date

Description	Please tick in the box		Please elaborate
	☐	z) Right Ring finger (two phalanges)	
	☐	aa) Left Ring finger (three phalanges)	
	☐	bb) Left Ring finger (two phalanges)	
	☐	cc) Left Ring finger (one phalanx)	
	☐	dd) Right Little finger (three phalanges)	
	☐	ee) Right Little finger (two phalanges)	
	☐	ff) Right Little finger (one phalanx)	
	☐	gg) Left Little finger (three phalanges)	
	☐	hh) Left Little finger (two phalanges)	
	☐	ii) Left Little finger (one phalanx)	
7.6 Leg: Total and irrecoverable loss of the effective use of	☐	a) Leg at Hip	
	☐	b) Leg between knee and hip	
	☐	c) Leg below knee	
7.7 Foot: Leg	☐	a) Fractured leg or patella with established non-union	
	☐	b) Shortening of leg by at least 5cm	
7.8 Foot: Loss of or permanent and total loss of use of	☐	a) All the toes of one foot	
	☐	b) Great toe – two phalanges	
	☐	c) Great toe – one phalanx	
	☐	d) Other than the great toe, each toe	
Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**			Date

Description	Please tick in the box		Please elaborate
7.9 Third Degree Burns: Burnt area as a percentage of the total body surface area: Degree Burns: Burnt area as a percentage of the total body surface area:	☐	a) Head – equal to or greater than 2% but less than 5%	
	☐	b) Head – equal to or greater than 5% but less than 8%	
	☐	c) Head – equal to or greater than 8%	
	☐	d) Body – equal to or greater than 10% but less than 15%	
	☐	e) Body – equal to or greater than 15% but less than 20%	
	☐	f) Body – equal to or greater than 20%	
	☐	g) at least 25% of the body surface (second degree deep partial thickness burn)	
7.10 Other injuries:	☐	a) Permanent and incurable insanity	
	☐	b) Total and permanent loss of teeth (subject to a minimum of 4 teeth)	
	☐	c) Removal of the lower jaw by surgical operation	

8 For Fractures, please provide details of the fracture in the table below:

Location of Bone fracture	Please tick in the box	Position of fracture
8.1 Hip or Pelvis (excluding thigh or coccyx)	☐	a) Open Fracture of more than one bone
	☐	b) Open Fracture of one bone
	☐	c) Closed Fracture of more than one bone
	☐	d) Closed Fracture of one bone
8.2 Thigh or Lower Leg	☐	a) Open Fracture of more than one bone
	☐	b) Open Fracture of one bone
	☐	c) Closed Fracture of more than one bone
	☐	d) Closed Fracture of one bone

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

Location of Bone fracture	Please tick in the box	Position of fracture
8.3 Elbows, Arm (including wrist but excluding Colles-type fractures)	☐	a) Open Fracture of more than one bone
	☐	b) Open Fracture of one bone
	☐	c) Closed Fracture of more than one bone
	☐	d) Closed Fracture of one bone
8.4 Colles* type fracture of the lower arm **Colles type fracture of the lower arm refers to distal end radius fracture without ulna fracture*	☐	a) Open Fracture
	☐	b) Closed Fracture
8.5 Skull	☐	a) Fracture of the skull needing surgical Intervention
	☐	b) Fracture of the skull not needing surgical Intervention
8.6 Shoulder Blade, Rib(s), Knee cap, Sternum, Hand (excluding fingers and wrist), Foot (excluding toes and heel)	☐	a) Open Fracture
	☐	b) Closed Fracture
8.7 Spinal Column (Vertebrae but excluding coccyx)	☐	a) All compression Fractures
	☐	b) All spinous, transverse process of pedicle Fractures
	☐	c) Permanent Spinal Cord damage
	☐	d) All vertebral Fractures
8.8 Lower Jaw	☐	a) Open Fracture
	☐	b) Closed Fracture
8.9 Cheekbone, Clavicle, Coccyx, Upper Jaw, Nose, Toe(s), Finger(s), Ankle, Heel	☐	a) Open Fracture of more than one bone
	☐	b) Open Fracture of one bone
	☐	c) Closed Fracture of more than one bone
	☐	d) Closed Fracture of one bone
8.10 Other Fracture	☐	Please elaborate:

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

9 For dislocation, please provide details of the dislocation in the table below:		
Location of Dislocation	Please tick in the box	Therapy
9.1 Spine	☐	a) Operation
	☐	b) Conservative
9.2 Back (excluding slipped disc)	☐	a) Operation
	☐	b) Conservative
9.3 Hip	☐	a) Operation
	☐	b) Conservative
9.4 Knee (left or right)	☐	a) Operation
	☐	b) Conservative
9.5 Wrist (left or right)	☐	a) Operation
	☐	b) Conservative
9.6 Elbow (left or right)	☐	a) Operation
	☐	b) Conservative
9.7 Ankle (left or right)	☐	a) Operation
	☐	b) Conservative
9.8 Shoulder blade (left or right)	☐	a) Operation
	☐	b) Conservative
9.9 Collarbone	☐	a) Operation
	☐	b) Conservative
9.10 Fingers (left or right hand)	☐	a) Operation
	☐	b) Conservative
9.11 Toes (left or right foot)	☐	a) Operation
	☐	b) Conservative
9.12 Jaw	☐	a) Operation
	☐	b) Conservative

10 For Internal Injury, please provide details of the injury in the table below	
Please tick in the box	Injured Organ
☐	Internal injuries resulting in open abdominal or Thoracic Surgery
☐	Intracranial haemorrhage and/ or physical brain injury
☐	Other Injured Organ : Please elaborate

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

11 Please indicate if the patient's condition is a result of any of the following activities:		
11.1 winter sports, ice hockey	Yes ( )	No ( )
11.2 horse riding, polo playing	Yes ( )	No ( )
11.3 canoeing, sailing or windsurfing	Yes ( )	No ( )
11.4 mountaineering, rock climbing, caving, potholing, hunting	Yes ( )	No ( )
11.5 hang gliding, sky diving, parachuting	Yes ( )	No ( )
11.6 scuba diving	Yes ( )	No ( )
11.7 boxing, wrestling, martial arts activities, whether in training or competition	Yes ( )	No ( )
11.8 motocross	Yes ( )	No ( )
11.9 military service	Yes ( )	No ( )

12 Is the above condition associated with the following:		
12.1 Any condition resulting from pregnancy, childbirth or miscarriage or abortion or pre & post natal care	Yes ( )	No ( )
12.2 Any form of dental care of surgery	Yes ( )	No ( )
12.3 Any treatment for obesity, weight management program	Yes ( )	No ( )
12.4 Eye test, refractive errors of eyes, photo refractive keratectomy, cosmetic or plastic surgery and the provision of appliances, including spectacles lenses, hearing aids, artificial organs or joints, wheelchair & prosthesis	Yes ( )	No ( )
12.5 Any elective surgery, cosmetic or plastic surgery not necessitated by injury	Yes ( )	No ( )
12.6 Routine health check-up, custodial or rest care	Yes ( )	No ( )
12.7 Mental illness, personality disorders, and psychiatric disorders	Yes ( )	No ( )
12.8 Infertility, impotence, contraception, sterilization, circumcision	Yes ( )	No ( )
12.9 Human Immunodeficiency Virus Infection, AIDS or any sexually transmitted diseases	Yes ( )	No ( )
Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**	Date	

12.10	Food poisoning	*Yes ( )*	*No ( )*
12.11	Illness or diseases as a result of bite inflicted by, and/or contact with, animal or insect, which animal or insect is infected by, or is a carrier of, such illnesses or diseases	*Yes ( )*	*No ( )*
12.12	Birth defect, including hereditary conditions and congenital anomalies	*Yes ( )*	*No ( )*
12.13	Alcohol, drug abuse or the use of unprescribed drugs where such drugs are required by law to be prescribed by a registered doctor	*Yes ( )*	*No ( )*
12.14	Self-inflicted injury e.g. voluntary causing hurt, suicide or attempted suicide	*Yes ( )*	*No ( )*
12.15	Vaccination	*Yes ( )*	*No ( )*

Past History

13 For the current injury / illness, were there any underlying illnesses or past injury that could have contributed to the current condition? (Please circle).	Yes	No

13.1 If yes, please give details below.

Diagnosis	Date of diagnosis (dd/mm/yy)	Name & address of doctor(s) consulted

13.2 How has the past or pre-existing illness contributed to the injuries or prolonged the period of disability?

14 Were you the first doctor who attended to this patient about this illness / injury? (Please circle)	Yes	No

14.1 Date you were first consulted for the injury / illness		DD		MM		YY

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 <u>mandatory</u> to enclose all relevant clinical, radiological, histological, operation and laboratory reports by attaching them to this page.