PRUDENTIAL

PruCustomer Line: 1800 -333 0 3333

# 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.

| | | |
|---|---|---|
| ☐ Acute Necrohaemorrhagic pancreatitis | ☐ Infective endocarditis | ☐ Progressive supranuclear palsy |
| ☐ Adrenalectomy for adrenal adenoma | ☐ Medullary cystic disease | ☐ Severe Crohn's disease |
| ☐ Creutzfeld-Jacob disease | ☐ Meningeal tuberculosis | ☐ Severe Eisenmenger's syndrome |
| ☐ Chronic auto-immune hepatitis | ☐ Multiple root avulsions of brachial plexus | ☐ Surgery for idiopathic scoliosis |
| ☐ Ebola | ☐ Necrotising fasciitis | ☐ Severe ulcerative colitis |
| ☐ Elephantiasis | ☐ Pheochromocytoma | ☐ Severe myasthenia gravis |
| ☐ Idiopathic pulmonary fibrosis | | |

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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 | | YY |
| 4. Date when Life Assured first consulted a doctor for the above signs or symptoms. | | DD | | MM | | YY |
| 5. 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:<br>• the name of police officer and police station at which the accident was reported; and<br>• a copy of the police report. | | | | | |
| 6. Has Life Assured previously suffered from or received treatment for a similar or related illness / injury? | | Yes | No | | | |
| If yes, please give details. | | | | | | |
| 7. 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 |
|---|---|---|---|
| | | | |

| | | | |
|---|---|---|---|
| | | | |

8. 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**

9. 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**

**PayNow (Default Payment Method)**
Any amount payable (if any) can only be made to the Policy Owner and will be paid via transfer to your **PayNow NRIC/FIN ID** by default. Please ensure that you have signed up for PayNow with your bank by linking it to your **NRIC/FIN**. Terms and conditions apply (https://www.prudential.com.sg/PN-tnc).

**To register for PayNow.**
Log in to your bank's internet or mobile banking account > Sign up for PayNow > Link your PayNow to your NRIC/FIN.

*Cheque will be issued for Policy Owners who do not have a valid Singapore NRIC/FIN or have opted out of PayNow as default in PRUaccess; payout recipient who is not the Policy Owner and Corporate entities.

**Direct Credit (Application Required)**
If you do not wish to receive payment via PayNow (NRIC/FIN), you may choose to receive payments via direct transfer to the Policy Owner's bank account.

Please fill in your bank details below and **submit** a copy of the policyowner's bank book or bank statement, stating the account holder's name and account number. We accept bank statements with the bank balances and transactions being blacked out, and truncated e-statements downloaded from the banks' mobile application, provided that the document shows the account holder's name and account number on the same page.

| Name of Account Holder | Name of Bank | Bank Account Number |
|---|---|---|
| | | |

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<br>(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.**

| | Critical Illness | Sections to be completed |
|---|---|---|
| 1 | Acute Necrohaemorrhagic pancreatitis | 1, 2, 21, 22 |
| 2 | Adrenalectomy for adrenal adenoma | 1, 3, 21, 22 |
| 3 | Creutzfeld-Jacob disease | 1, 4, 21, 22 |
| 4 | Chronic auto-immune hepatitis | 1, 5, 21, 22 |
| 5 | Ebola | 1, 6, 21, 22 |
| 6 | Elephantiasis | 1, 7, 21, 22 |
| 7 | Idiopathic pulmonary fibrosis | 1, 8, 21, 22 |
| 8 | Infective endocarditis | 1, 9, 21, 22 |
| 9 | Medullary cystic disease | 1, 10, 21, 22 |
| 10 | Meningeal tuberculosis | 1, 11, 21, 22 |
| 11 | Multiple root avulsions of brachial plexus | 1, 12, 21, 22 |
| 12 | Necrotising fasciitis | 1, 13, 21, 22 |
| 13 | Pheochromocytoma | 1, 14, 21, 22 |
| 14 | Progressive supranuclear palsy | 1, 15, 21, 22 |
| 15 | Severe Crohn's disease | 1, 16, 21, 22 |
| 16 | Severe Eisenmenger's syndrome | 1, 17, 21, 22 |
| 17 | Surgery for idiopathic scoliosis | 1, 18, 21, 22 |
| 18 | Severe ulcerative colitis | 1, 19, 21, 22 |
| 19 | Severe myasthenia gravis | 1, 20, 21, 22 |

| 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 | | 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 |
| 5. Please provide exact diagnosis: | | | | | | |
| 6. What is/are the underlying cause(s)? | | | | | | |
| 7. Date of diagnosis. | | DD | | MM | | YY |
| 8. Date when patient / patient's next of kin first informed of the diagnosis. | | DD | | MM | | YY |
| 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/yy | To dd/mm/yy | |
| 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 | | 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. | | | | | | |

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

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

| **SECTION 2 : 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/yy) | |
| 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. | | |

| **SECTION 3 : 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 4 : 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 became 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 |
|---|---|---|
| Signature & Practice Stamp of the Medical Specialist who filled up Part II | Date | |

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

| | | |
|---|---|---|
| **SECTION 5 : 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 6 : 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 |
| **SECTION 7 : 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 8 : 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:<br>- FVC $\leqslant$ 50%?<br>- DLCO $\leqslant$ 35%<br>of predicted value? | Yes<br>Yes | No<br>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. | | |
| Signature & Practice Stamp of the Medical Specialist who filled up Part II | Date | |

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

| | | |
|---|---|---|
| **SECTION 9 : 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 |
| 3. Was the diagnosis of infective endocarditis and the severity of valvular impairment confirmed by a cardiologist? | Yes | No |
| **SECTION 10 : 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 11 : 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. | | |
| 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 12 : 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 |

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

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

| **SECTION 13 : 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 14 : 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. | | |
| **SECTION 15 : 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 became unable to perform such ADLs? | Is the inability to perform the ADL permanent? |
|---|---|---|---|
| Washing | | | |
| Dressing | | | |
| Transferring | | | |
| Mobility | | | |
| Toileting | | | |
| Feeding | | | |

| **SECTION 16 : 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<br>Please provide us with a copy of the histology report. | Yes | No |
| Signature & Practice Stamp of the Medical Specialist who filled up Part II | Date | |

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

| | | | |
|---|---|---|---|
| **SECTION 17 : 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. | | |
| 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 18 : 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 19 : 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 |

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

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

| **SECTION 20 : 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 |

| **SECTION 21 : 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 YY | |
| 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 |
|---|---|---|---|---|
| | | | | |

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

| 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 | |

# SECTION 22
# 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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