PRUDENTIAL

PRUAFFINITY PERSONAL ACCIDENT CLAIM FORM

Important Note

1. 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.
2. The Company reserves the right to request for additional documents when deemed necessary.

SECTION 1 (This section is to be completed by the Life Assured / Claimant.)

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

POLICY NUMBER
00104673

TYPE OF CLAIM
Mandatory documents for claim submission • PRUAFFINITY PERSONAL ACCIDENT 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.**
☐	**Accident Death Benefit**	• Certified True Copy of Death Certificate by company • Coroner's Certificate • Post Mortem • Newspaper article (if available) • Police Report (if available) • Current employer's job termination letter (if applicable) • NRIC of Claimant • Proof of Relationship (eg. Marriage Cert, Birth Cert, etc)
☐	**Accidental Dismemberment Benefit**	• Newspaper article (if available) • Police Report (if available) • Current employer's job termination letter. (if applicable)
☐	**Hospital Income** (Hospitalisation due to Dengue Haemorrhagic Fever)	• A copy of the hospitalization bills

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/injury 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 injury.

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, AUTHORISATION AND CONSENT

1. I hereby declare that the statements and answers given in this form are true and complete to the best of my knowledge and belief, and further, that I have not made any false or fraudulent statement, suppressed or concealed any facts.

2. For the purposes of (a) 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, (b) customer servicing, statistical analysis, conducting customer due diligence, reporting to regulatory or supervisory authorities, auditing and recovery of any debts owing to Prudential Assurance Company Singapore (Pte) Limited ("**PACS**") under this policy, (c) storage and retention, (d) meeting requirements of prevailing internal policies of PACS, and (v) as set out in PACS Privacy Notice ("**Purpose**"), I authorise, agree and consent to:

(i) Any person(s) or organisation(s) that has relevant information concerning the policyowner and the life assured (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

(ii) Prudential collecting, using, disclosing, releasing, transferring and exchanging personal data about me, the policyowner and the life assured, with any 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 assisting with my claim for the Purpose.

3. 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 or where applicable, the consent of the legal personal representative of the deceased life assured, 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.

4. 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 a 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.

5. I understand and agree that a photocopy of this authorisation shall be as valid as the original.

Signature of Life Assured / Claimant	Date

The following section is to be completed if the Claimant is not the Life Assured.

Name of Claimant		NRIC of Claimant	
Email Address			
Address			
Relationship to deceased		Contact No.	

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, Name of Employer and Company Address		

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?

Temporary Total Disability – If Life Assured cannot engage in all duties of his usual occupation, business or activities)	From (dd/mm/yy)	To (dd/mm/yy)
Temporary Partial Disability - If Life Assured can engage in partly duties of his usual occupation, business or activities)	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	**Dengue Haemorrhagic Fever (To be completed for Hospital Income Benefit)**							
7.1	Is the patient diagnosed with Dengue Haemorrhagic Fever? (Please circle).						Yes	No
7.1.1	If No, please state the type of dengue fever that the patient was diagnosed with.							
7.1.2	If Yes, what is the staging of patient's Dengue Haemorrhagic Fever according to the World Health Organization (WHO) Classification? ☐ Grade I ☐ Grade II ☐ Grade III ☐ Grade IV							
7.2	Did the patient's Dengue Haemorrhagic Fever result in Dengue Shock Syndrome (DSS), with the following findings? (Please circle)							
	• hypotension of less than 80 mm Hg						Yes	No
	• narrow pulse pressure of 20mm Hg or less						Yes	No
	• evidence of tissue hypoperfusion such as cold, clammy skin, oliguria, or a metabolic acidosis?						Yes	No
	• Others, please provide details.							

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

8 *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
8.1 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:			
8.2 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	
8.3 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	
Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**			Date

Description	Please tick in the box		Please elaborate
8.4 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	
8.5 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	
	☐	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)	
Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**			Date

Description	Please tick in the box		Please elaborate
	☐	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)	
	☐	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)	

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

Description	Please tick in the box		Please elaborate
8.6 Leg: Total and irrecoverable loss of the effective use of	☐	a) Leg at Hip	
	☐	b) Leg between knee and hip	
	☐	c) Leg below knee	
8.7 Foot: Leg	☐	a) Fractured leg or patella with established non-union	
	☐	b) Shortening of leg by at least 5cm	
8.8 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	
8.9 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)	

9 Please indicate if the patient's condition is a result of any of the following activities:		
9.1 winter sports, ice hockey	Yes ( )	No ( )
9.2 horse riding, polo playing	Yes ( )	No ( )
Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**	Date	

9.3 canoeing, sailing or windsurfing	Yes ( )	No ( )
9.4 mountaineering, rock climbing, caving, potholing, hunting	Yes ( )	No ( )
9.5 hang gliding, sky diving, parachuting	Yes ( )	No ( )
9.6 scuba diving	Yes ( )	No ( )
9.7 boxing, wrestling, martial arts activities, whether in training or competition	Yes ( )	No ( )
9.8 motocross	Yes ( )	No ( )
9.9 military service	Yes ( )	No ( )

10 Is the above condition associated with the following:		
10.1 Birth defect, including hereditary conditions and congenital anomalies	*Yes ( )*	*No ( )*
10.2 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 ( )*
10.3 Self-inflicted injury e.g. voluntary causing hurt, suicide or attempted suicide	*Yes ( )*	*No ( )*

Past History		
11 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

11.1 If yes, please give details below.

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

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

12 Were you the first doctor who attended to this patient about this illness / injury? (Please circle)					Yes	No
12.1 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 mandatory to enclose all relevant clinical, radiological, histological, operation and laboratory reports by attaching them to this page.