PRUSHIELD CLAIM FORM (Manual Submission)

(Inpatient / Day Surgery / Outpatient Chemotherapy or Radiotherapy or Immunotherapy or Renal Dialysis)

Important Note:

- The Company does not admit liability by the mere submission of this form and the required documents.
- 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.

PruShield Policy Number

Please select the type of benefit you wish to claim and fill in the respective sections as indicated by the '√'.

Tick	Type of Benefit Claim	Section you need to complete (√: This section is required to be completed)				
		Section 1	Section 2	Section 3	Section 4	Section 5
☐	Inpatient (Singapore)	√	√	√		√
☐	Day Surgery (Singapore)	√	√	√		√
☐	Outpatient (Singapore) - Chemotherapy - Radiotherapy - Immunotherapy - Renal dialysis	√	√	√		√
☐	Emergency Overseas Inpatient	√	√	√		√
☐	Planned Overseas Inpatient or Day Surgery	√	√	√		√
☐	Living Organ Donor Transplant (When Life assured is Living organ recipient)	√	√	√	√	√
☐	Living Organ Donor Transplant (When Life assured is the Living organ donor)	√	√		√	√

Section 1 – Life Assured's Particulars: To be completed by life assured
Section 2 – Hospital Admission Detail/ Medical Information of the life assured: To be completed by life assured
Section 3 – Admission Details: To be completed by life assured's doctor
Section 4 – Admission Details (Organ Transplantation): To be completed by organ recipient's doctor and organ donor's doctor
Section 5 – Reports

Required supporting documents checklist

	Document	Condition
☐	Prushield Claim Form	Compulsory
☐	Clinical Abstract Application Form	Compulsory
☐	Original final hospital bill, tax invoice and receipt of life assured	Compulsory
☐	Certified true copy of passport	Life Assured is Foreigner (Non PR)
☐	Certified true copy of valid pass	Life Assured is Foreigner (Non PR)
☐	Certified true copy of death certificate	Life Assured is deceased
☐	Proof of relationship of claimant to deceased life assured (e.g. marriage certificate, birth certificate)	Life Assured is deceased
☐	Death claimant's statement	Life Assured is deceased
☐	Certified true copy of identification documents of claimant	Life Assured is deceased
☐	Copy of identification documents of living organ donor	Life Assured is organ recipient
☐	Clinical Abstract Application Form signed by living organ donor	Life Assured is organ recipient
☐	Original final hospital bill, tax invoice and receipt of living organ donor	Life Assured is organ recipient

Note:
All non-English documents need to be translated into English by a certified translator. The translated documents must be authenticated by a Notary Public.

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SECTION 1 – Life Assured's Particulars

This section is to be completed by Life Assured. If the Life Assured is below 18 years old, parent or legal guardian may assist with the completion.

Full Name		NRIC/ FIN No.	
Contact No.		Date of Birth	
Address		Occupation	

If the life assured is foreigner, please fill in the section below:

Tick	**Type of valid pass**	**Expiry date (dd/mm/yy)**
☐	Personalised Employment Pass (PEP)	
☐	Employment Pass (EP)	
☐	S Pass	
☐	Student Pass	
☐	EntrePass	
☐	Long Term Visit Pass (LTVP)	
☐	Dependant's Pass (DP)	

Claim can only be considered if the event occurred within the expiry date of the valid pass.

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

SECTION 2 - Hospital Admission Detail/ Medical Information of the life assured

This section is to be completed by Life Assured. If the Life Assured is below 18 years old, parent or legal guardian may assist with the completion.

2.1 Date of Hospitalisation (dd/mm/yy)

From:	To:

2.2 Name of Hospital admitted

2.3 What is the treatment type? Please indicate in the following:

☐ Inpatient treatment
☐ Day surgery without ward admitted
☐ Short Stay ward / Observation ward (without admission to a standard ward for hospital confinement)
☐ Outpatient Chemotherapy/radiotherapy/immunotherapy
☐ Outpatient Renal dialysis

2.4 Who had referred the life assured to the hospital?

Name of Doctor:

Clinic Name/ Branch:

Address:

Dates of Consultation (dd/mm/yy):

HOSPITALISATION DUE TO AN ILLNESS

2.5 What was the diagnosis made on the life assured?

2.6 When did the life assured first notice the symptoms of this illness?

2.7 Describe the symptoms of the illness.

2.8 When did the life assured first seek medical attention on this illness?

2.9 Describe the treatment given to the life assured by the doctor.

HOSPITALISATION DUE TO AN INJURY CAUSED BY AN ACCIDENT

2.10 Date of Accident (dd/mm/yy)

2.11 Place of Accident

2.12 How did it occur?

2.13 Was there any witness(es) when the accident occurred?
☐ Yes ☐ No

Name of Witness:
Contact No:
Relationship to you:

2.14 Was a police report filed? If yes, please enclose a copy.
☐ Yes ☐ No

2.15 Describe the injury of the life assured.

2.16 When did the life assured first seek medical attention on this injury?

2.17 Describe the treatment given to the life assured by the doctor.

2.18 Has the life assured previously received treatment for this injury? If yes, please provide the following information.
☐ Yes ☐ No

Name of Doctor:

Name & Address of Clinic/ Hospital:

Dates of Consultation (dd/mm/yy):

Reason for Visit:

2.19 Are you claiming from other sources?
☐ Yes ☐ No
If yes, please provide us the following information:

Name of third party:

Amount claimed:

Please provide us a copy of settlement letter from third party if you have already claimed from third party.

HOSPITALISATION DUE TO ORGAN TRANSPLANT

2.20 Information of Living Organ Donor

Name of Living Organ Donor:	
NRIC/ FIN Name:	
Nationality:	
Date of birth (dd/mm/yy):	
Occupation:	
Marital Status:	
Contact No:	
Full Address:	

2.21 Hospital Admission Detail of Living Organ Donor

Name of admitted hospital:	
Date of admission (dd/mm/yy):	
Date of discharge (dd/mm/yy):	

I hereby declare that all information given by me in this section is, to the best of my knowledge and belief, true and complete.

Name:

Name & Signature of Life Assured who is above 18 years old

Date (dd/mm/yy)

Name:

Name & Signature of Policy owner

Date (dd/mm/yy)

Relationship of Policy owner to Life Assured

SECTION 3 - Admission Details

To be completed by life assured's doctor

Name of Specialist Doctor:

Medical Council Registration No:

Practicing Medical Institution:

3.1 Type of Medical Treatment

☐ Inpatient treatment
☐ Day surgery without admitting to standard ward
☐ Short Stay ward / Observation ward (without admission to a standard ward for hospital confinement)
☐ Outpatient Chemotherapy/radiotherapy/immunotherapy
☐ Outpatient Renal dialysis

Admission Date (dd/mm/yy): ____________________ Discharge Date (dd/mm/yy): ____________________

Name of Hospital Admitted: ____ ☐ Private ☐ Public

3.2 Inpatient Admission Details

Duration of Stay		Please tick the number of bed in the ward/room*						
From (dd/mm/yy)	To (dd/mm/yy)	1	2	3	4	5	6	>6

** Please refer to the definition below:*

1-bed = A ward of Singapore Restructured hospital
2 to 4-bed = B1 ward of Singapore Restructured hospital
5 or 6-bed = B2 ward of Singapore Restructured hospital
More than 6-bed = C ward of Singapore Restructured hospital
(Note: If there is no indication of number of bed, deductible of 1-bed will be applied to the claim)

3.3 How was the patient admitted?

☐ A&E Admission
☐ Referred by a doctor (Please provide the name and practice address of the doctor)

Name:
Name & Signature of Specialist Doctor

Date:
Practice Stamp & Date

3.4 Diagnosis Established During Current Admission

S/N	**Diagnosis**	**ICD 10 AM**	**Organ/ part of body involved (if applicable)**	**Date the diagnosis first established** (dd/mm/yy)	**Date patient/next of kin was informed of the diagnosis** (dd/mm/yy)	**Information regarding the diagnosis given to patient/next of kin**
1			Organ: Body Part: ☐ Left ☐ Right			
2			Organ: Body Part: ☐ Left ☐ Right			
3			Organ: Body Part: ☐ Left ☐ Right			

3.5 Information of Each of the Illness/ Injury stated in Section 3.4 during **First Consultation**

Ref to 3.4 S/N	**Illness/ Injury stated in 3.4**	**Date of 1st Consultation** (dd/mm/yy)	**Symptoms presented**	**Diagnosis**	**Information regarding the diagnosis given to patient/next of kin**
1					
2					
3					

3.6 **Underlying Disease** of Each of Illness/ Injury Stated in Section 3.4

Ref to 3.4 S/N	**Illness/ Injury stated in 3.4**	**Underlying disease**		
		Congenital	**Accident** (dd/mm/yy)	**Other** (Please state full diagnosis of the underlying disease)
1		☐Yes ☐ No	☐Yes ☐ No Date of accident:	
2		☐Yes ☐ No	☐Yes ☐ No Date of accident:	
3		☐Yes ☐ No	☐Yes ☐ No Date of accident:	

Name:
Name & Signature of Specialist Doctor

Date:
Practice Stamp & Date

3.7 Details of Each Underlying Disease Mentioned in 3.6

S/N	**Underlying Disease**	**Date Diagnosis 1st Established** (dd/mm/yy)	**Date patient/kin was informed of the diagnosis** (dd/mm/yy)	**Information regarding the diagnosis given to patient/next of kin**
1				
2				
3				

3.8 Full Details of Treatment Applied for Each Illness/ Injury stated in 3.4

S/N	**Illness/ Injury stated in 3.4**	**Surgery**	**Is general or local anaesthesia applied?**	**TOSP Code of Surgery**	**Date of Surgery** (dd/mm/yy)	**Name of medication exclusively applied for illness/ injury**
1		1	☐Yes ☐ No			
		2	☐Yes ☐ No			
		3	☐Yes ☐ No			
2		1	☐Yes ☐ No			
		2	☐Yes ☐ No			
		3	☐Yes ☐ No			
3		1	☐Yes ☐ No			
		2	☐Yes ☐ No			
		3	☐Yes ☐ No			

3.9 Does the medical condition(s) mentioned in Question 3.4 require urgent remedial treatment to avoid death, or serious impairment to the life assured's health or treatment can be delayed?

☐ Immediate treatment required
☐ Treatment can be delayed

If the answer is "Immediate treatment required", please advise how does the delay in treatment result in death or serious impairment to the life assured's health?

Name:	Date:
Name & Signature of Specialist Doctor	*Practice Stamp & Date*

3.10 Was the patient treated for any illness/injury mentioned in 3.4 and 3.6 previously?
☐ Yes ☐ No

If Yes, please give further details of previous treatment as follows:

S/N	**Diagnosis**	**Date of Diagnosis** (dd/mm/yy)	**Date patient/next of kin was informed of the diagnosis** (dd/mm/yy)	**Information regarding the diagnosis given to patient/next of kin**
1				
2				
3				

3.11 Does the patient have any other chronic disease?
☐ Yes ☐ No

If Yes, kindly give further details of history of other chronic diseases as follows:

S/N	**Diagnosis**	**Date of Diagnosis** (dd/mm/yy)	**Date patient/next of kin was informed of the diagnosis** (dd/mm/yy)	**Name and address of doctor who treated and followed up for the illness/injury**
1				
2				
3				

Name:
Name & Signature of Specialist Doctor

Date:
Practice Stamp & Date

3.12 Are the illnesses/ injuries stated in 3.4 and treatment applied in 3.8 associated with the following?
If Yes, kindly give details of treatment i.e. medication prescribed and/or procedure/operation performed.

S/N	Illness/ Injuries	Name of Medication prescribed	Name of Procedure/ Operation performed
1	Mental illness and personality disorder ☐ Yes ☐ No		
2	Pregnancy, or any form of hospitalization or treatment relating to pregnancy, childbirth, abortion or miscarriage Gestation period ( ) weeks ☐ Yes ☐ No		
3	Infertility, sub-fertility, assisted conception or any contraceptive treatment ☐ Yes ☐ No		
4	Treatment of sexually transmitted diseases ☐ Yes ☐ No		
5	Acquired Immunodeficiency Syndrome (AIDS), AIDS related complex or infection by Human Immunodeficiency Virus (HIV) ☐ Yes ☐ No		
6	Treatment of self-inflicted injuries, or injuries resulting from attempted suicide ☐ Yes ☐ No		
7	Treatment for drug addiction or alcoholism ☐ Yes ☐ No		
8	Cosmetic surgery except for medical reasons ☐ Yes ☐ No		
9	Dental treatment except for medical reasons ☐ Yes ☐ No		
10	Sex change operations ☐ Yes ☐ No		
11	Treatment of Injuries arising from direct participation in civil commotion, riots or strikes ☐ Yes ☐ No		
12	Treatment of Injuries arising directly or indirectly from nuclear fallout, terrorism, wars and related risks ☐ Yes ☐ No		
13	Is this hospitalization primarily for diagnosis, X-ray examination and general physical or medical check up? ☐ Yes ☐ No	*Not applicable*	*Not applicable*
14	Is this hospitalization for organ transplantation? ☐ Yes ☐ No If YES, kindly complete Section 4.	*Not applicable*	*Not applicable*

I hereby declare that the above answers are true to the best of my knowledge and belief. I agree for a copy of this report to be made available to the patient or the relevant authorities upon their request.

Name:	Date:
Name & Signature of Specialist Doctor	*Practice Stamp & Date*

SECTION 4 - Admission Details (Organ Transplantation)

To be completed by organ recipient's doctor and organ donor's doctor

Part 1 – Medical Information of Organ Recipient to be completed by Specialist Doctor of Organ Recipient

Name of attending Specialist Doctor of organ recipient:

Medical Council Registration No:

Practicing Medical Institution:

Name of the organ recipient: ______________________________

NRIC/ FIN of the organ recipient: ______________________________

4.1 Admission details of Organ Recipient for Organ Transplantation

Name of admitted hospital:	
Hospital Registration Number (HRN):	
Date of admission (dd/mm/yy):	
Date of discharge (dd/mm/yy):	

4.2	Which organ is involved in the Organ Transplantation?	☐ Liver ☐ Kidney ☐ Other:
4.3	What is the diagnosis of the organ failure that required transplantation of organ mentioned in question 4.2?	Diagnosis of organ failure: ICD 10 AM Code:
4.4	Date life assured first consulted for the organ failure mentioned in question 4.3 (dd/mm/yy)	
4.5	What is the symptom of organ failure mentioned in question 4.3 during first consultation?	
4.6	Date the organ recipient is made aware of the symptom mentioned in question 4.5 (dd/mm/yy)	
4.7	Date diagnosis of organ failure mentioned in question 4.3 was first established (dd/mm/yy)	
4.8	Name and address of Practice Institution of doctor(s) who referred organ recipient to you	Name: Address:
4.9	Details of surgery of organ transplantation applied for organ recipient	Type of surgery: TOSP code: Date of surgery (dd/mm/yy):

I hereby declare that the above answers are true to the best of my knowledge and belief. I agree for a copy of this report to be made available to the patient or the relevant authorities upon their request.

Name:	Date:
Name & Signature of Organ Recipient Specialist Doctor	*Practice Stamp & Date*

Part 2 - Medical Information of the Living Organ Donor to be completed by Specialist Doctor of Living Organ Donor

Name of Specialist Doctor:

Medical Council Registration No:

Practicing Medical Institution:

Name of the living organ donor: ______________________________

NRIC/ FIN of the living organ donor: ______________________________

4.10 Admission details of Living Organ Donor for Organ's Donation

Name of admitted hospital:	
Hospital Registration Number (HRN):	
Date of admission (dd/mm/yy):	
Date of discharge (dd/mm/yy):	
What is the diagnosis established during admission?	Diagnosis: ICD10AM code:
What is status of organ donor at moment to harvest organ?	☐ Living. ☐ Deceased
Type of surgery applied for living organ donor and TOSP code	Type of Surgery: TOSP code:

I hereby declare that the above answers are true to the best of my knowledge and belief. I agree for a copy of this report to be made available to the patient or the relevant authorities upon their request.

Name:
Name & Signature of Living Organ Donor's Specialist Doctor

Date:
Practice Stamp & Date

SECTION 5 - Reports

Please enclose:
All relevant clinical, radiological, operation and laboratory reports to this section.
Referral letter if there is any.

Name of enclosed documents

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