PRUDENTIAL

PruCustomer Line: 1800 -333 0 3333

# FEMALE BENEFIT CLAIM FORM
**(PRUSMART LADY & PRULADY)**

**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)**

### 1. DETAILS OF POLICY

Policy Number(s) of the benefit(s) you would like to claim:

### 2. DETAILS OF LIFE ASSURED

| | | | |
|---|---|---|---|
| Full Name | | NRIC No. | |
| Address | | Contact No. | |
| Date of birth | (DD/MM/YYYY) | Occupation | |

### 3. TYPE OF CLAIM

3 Please tick the appropriate box for the Female Illness / Medical Conditions you are claiming.

| Female Illnesses | | Medical Procedure due to Malignant Condition | | Support benefit | |
|---|---|---|---|---|---|
| Malignant Cancer/ Choriocarcinoma | | Radical vulvectomy | | Oocyte Cryopreservation due to covered female cancers | |
| Carcinoma in situ of breast/ cervix uteri | | Wertheim's operation | | Molecular Gene Expression Profiling test for breast cancer | |
| **Reconstructive Surgery** | | Total pelvic exenteration | | Hormone Replacement Therapy due to Cancer | |
| Breast reconstructive surgery following a mastectomy | | Hysterectomy | | Outpatient Psychiatric benefit due to female cancer | |
| Skin grafting due to skin cancer | | Mastectomy | | | |
| | | Bilateral/ unilateral breast lumpectomy | | | |

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## 4. NATURE OF CLAIM

4.1 Please describe fully the extent and nature of illness.

4.2 Have you previously suffered from or received treatment for a similar or related illness / injury? If yes, please give details.

4.3 Please provide the details of all the doctors who had attended to you:-

| Name of doctor consulted | Address of doctor | Date first consulted for this illness |
|---|---|---|
| | | |

4.4 Please provide the details of your regular doctor and company doctor whom you have 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 (DD/MM/YYYY) | Reason(s) for consultation |
|---|---|---|---|
| | | | |

## 5. OTHER INSURANCE

5 Are you insured for similar benefits with any other company? If yes, please give full details :-

| Name of Insurer | Type of Plan | Date of Issue | Benefit Amount |
|---|---|---|---|
| | | | |

## 6. 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

**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 | | | |

**SECTION 1**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. Are you the insured's usual doctor? | | | | | Yes / No | | |
| 2. Over what period do your records extend?<br>Start date: _____ (DD/MM/YYYY) End date: _____ (DD/MM/YYYY) | | | | | | | |
| 3. Date you were first consulted for the condition | | DD | | MM | | YY | |
| 4. What were the presenting symptoms when you first saw the patient? | | | | | | | |
| 5. When did the above symptoms first started? | | DD | | MM | | YY | |
| If the date is unknown, please state how long the symptoms had been present prior to the date of first consultation. | | | | | | | |
| 6. What was the diagnosis? | | | | | | | |
| 7. Date of diagnosis | | DD | | MM | | YY | |
| 8. Date diagnosis was made known to the patient | | DD | | MM | | YY | |
| 9. If the patient was referred to you for further management, please provide the name and practice address of the referral doctor. | | | | | | | |
| 10. Please provide the name and address of the patient's regular attending doctor. | | | | | | | |

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

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

| **SECTION 2** | | |
|---|---|---|
| **Please complete Question 1 to 8 if patient's condition is on:**<br>**Malignant Cancer/ Choriocarcinoma**<br>**Carcinoma-in-situ of breast/ cervix uteri**<br>**Medical Procedure due to a malignant condition**<br>**Reconstructive surgery following a mastectomy**<br>**Skin grafting due to skin cancer** | | |
| 1. Please state the origin of the malignant tumor. | | |
| 2. What is the staging of the tumor? Please indicate the TNM staging or its equivalent. | | |
| 3. Were regional lymph nodes involved? | Yes | No |
| 4. Is this an invasive cancer based on the histology report?<br>(please attach a copy of the histology report) | Yes | No |
| 5. Is the tumor histologically described as pre-malignant or non-invasive, including but not limited to Carcinoma-in-situ, Cervical Dysplasia, CIN-I, CIN-II, HSIL or LSIL? | Yes | No |
| 6. Has the tumor been surgically excised? | Yes | No |
| a. Please state the nature of the surgery performed and date of the surgery (please attach a copy of the operation report). | | |
| 7. Please confirm if the surgery that was done was due to a diagnosis of invasive cancer. | Yes | No |
| 8. Did the patient undergo any reconstructive surgery or skin grafting due to cancer? | Yes | No |
| a. If yes, please state the nature of the operation and when it was performed (please attach a copy of the operation report). | | |

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

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

| | | |
|---|---|---|
| **Please complete Question 9 to 11 if patient's condition is on:<br>Oocyte Cryopreservation** | | |
| 9. Has the insured been prescribed to undergo chemotherapy or radiotherapy? | Yes | No |
| 10. Has the patient been recommended for cryopreservation? | Yes | No |
| 11 a. Has the patient utilized the services for cryopreservation of mature oocytes (eggs) or embryos? | Yes | No |
| b. If yes, please provide the date of cryopreservation | (DD/MM/YYYY) | |
| c. Was this cryopreservation utilized before chemotherapy or radiotherapy from a registered cryopreservation centre? | Yes | No |
| **Please complete Question 12 to 13 if patient's condition is on:<br>Molecular Gene Expression Profiling test for Breast cancer** | | |
| 12. Was an immunohistochemistry testing done to confirm the breast tumor as estrogen receptor positive? | Yes | No |
| Please provide a copy of the immunohistochemistry report and/ or hormone receptor assay. | | |
| 13. Have you recommended Molecular Gene Expression Profiling Test? | Yes | No |
| **Please complete Question 14 to 19 if the patient's condition is on:<br>Hormone replacement therapy after oophorectomy and/ or hysterectomy** | | |
| 14. Has the patient undergone oophorectomy and/ or hysterectomy? | Yes | No |
| 15. Please state the nature of the operation and when it was performed<br>Please also provide a copy of the operation notes/ reports. | | |
| 16. Is the oophorectomy and/ hysterectomy bilateral? | Yes | No |
| 17. Is the procedure performed due to Cancer? | Yes | No |
| 18. Was hormone replacement therapy (HRT) advised after the surgery? | Yes | No |
| 19. Please describe the symptoms that have necessitated the HRT. | | |

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

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

| **Please complete Question 20 to 24 if the patient's condition is on:<br>Psychiatric condition due to traumatic life event – Cancer** | | |
|---|---|---|
| 20. Was the patient diagnosed with Major Depressive Disorder (MDD? And/ or Anxiety Disorders? | Yes | No |
| 21. Was the patient's Major Depressive Disorder (MDD) and/ or Anxiety Disorder caused by Cancer? | Yes | No |
| 22. If yes, please specify the site of cancer. | | |
| 23. What was the treatment prescribed for MDD and/ or Anxiety Disorder? | | |
| 24. Was the patient under medication for at least 6 continuous months? | Yes | No |
| **SECTION 3** | | |
| 1. Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? | Yes | |
| If yes, please provide the date of diagnosis of HIV/ AIDS. | (DD/MM/YYYY) | |
| 2. Is the diagnosis related to a deliberate act of taking intoxicating liquor, drugs or poison, suicide or attempted suicide or intentional self-injury? | Yes | No |
| If yes, please provide details. | | |
| 3. Is the diagnosis related to the use of unprescribed drugs where such drugs are required by law to be prescribed by a registered medical practitioner? | Yes | No |
| If yes, please provide details. | | |

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

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

| **SECTION 4** | | |
|---|---|---|
| 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 the patient mentally incapacitated? | Yes | No |
| 2. Is the patient suffering from any significant medical condition?<br>If yes, please provide the following information: | Yes | No |
| a) Date of diagnosis<br>_____(DD/MM/YYYY)<br>b) Name and practice address of the doctor who had diagnosed/ treated the patient. | | |
| 3. Please provide details of the patient's personal medical history and any further information about the patient, which may be of assistance to us in assessing this claim? | | |

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

## PART III
## 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.

Prudential Assurance Company Singapore (Pte) Limited
Postal Address: Robinson Road P.O. Box 492 Singapore 900942
Telephone: 6535 8988 Fax: 6734 9555 Website: www.prudential.com.sg
Part of Prudential Corporation plc Reg. No 199002477Z