HOSPITAL CARE BENEFIT CLAIM FORM
(PRUSMART LADY, PRULADY, PRUFIRST GIFT, PRUFIRST PROMISE)

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. The Company reserves the rights to request for additional documents when deemed necessary.

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

3.1 Please circle and tick the appropriate box for the Hospital Care benefit you are claiming.

HOSPITAL CARE (CHILD)		HOSPITAL CARE (MOTHER)	
Hospitalisation of child due to: - Incubation of newborn child for more than 3 consecutive days immediately following birth - Premature birth requiring neonatal ICU - Bronchitis - Dengue hemorrhagic fever - Phototherapy for severe neonatal jaundice - Pneumonia - Severe measles - Severe Hand, Foot and Mouth Disease (HFMD) - Chikungunya fever - Typhoid fever - Rabies - Zika - MERS-CoV - Ebola - SARS - Influenza A – Avian Influenza (H7N9 and A(H5N1) - Nipah virus encephalitis - Japanese encephalitis - Creutzfeldt-Jakob disease - Malaria		Hospitalisation of life assured (mother) due to: - Zika - Inpatient Psychiatric Treatment - Post-natal anaemia - Puerperal Pyrexia - Pulmonary Embolism - Repair of 4th degree perineal tear - Septic pelvic thrombophlebitis - Surgical Site infection following caesarian section - Uterine infection or transfusion due to retained placenta following childbirth - Complications of Lactational Mastitis	
Hospital care accelerator		Hospital care accelerator	

C230125

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 (please tick the appropriate)

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 (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 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			

SECTION I

1. Are you the insured's usual doctor?							Yes / No
2. Over what period do your records extend? 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. What was the exact information regarding the diagnosis that the patient or patient's next of kin was informed on the date stated in (7) above.							

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

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

10. 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 and had treated the patient for this condition.
b. Date the diagnosis was made by the previous doctor.
c. If the patient was referred to you for further management, please provide the name and practice address of the referral doctor. Please provide a copy of the referral letter.
11. What medical treatment has the patient been receiving? When did each of the treatment commence?
12. Please provide the name and address of the patient's regular attending doctor.
13. What is the patient's prognosis?

SECTION II

Please complete Question 1 if patient's condition is on:
Incubation of a newborn child for more than 3 consecutive days immediately following birth

1. Was the child incubated for more than 3 consecutive days immediately following birth? If yes, please state the period of confinement: _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No

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

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

Please complete Question 2 to 3 if the patient's condition is on: **Premature birth requiring neonatal ICU**		
2. Was the child born prematurely? If yes, please provide the following information: i) gestation period ____ weeks ii) birth weight ____ grams	Yes	No
3. Was the child admitted to a neonatal intensive care unit (NICU) or High Dependency Unit (HDU)? If yes, please state the period of confinement _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
Please complete Question 4 if the patient's condition is on: **Hospitalisation of life assured's child due to Bronchitis**		
4. Was the child admitted for bronchitis? Please state the period of confinement (including ICU and HDU ward, if any): _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY) Period in ICU: _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY) Period in HDU: _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
Please complete Question 5 to 7 if the patient's condition is on: **Hospitalisation of life assured's child due to Dengue Hemorrhagic Fever**		
5. Was the child admitted for dengue hemorrhagic fever? Please state the period of confinement (including ICU and HDU ward, if any): _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY) Period in ICU: _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY) Period in HDU: _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No

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

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

6. What is the grade of the patient's Dengue Hemorrhagic Fever based on WHO classification? Grade 1/ 2/ 3/ 4 (please circle)		
7. Were any of the following findings present?		
- History of continuous high fever (for 2 or more days)	Yes	No
- Minor or major hemorrhagic manifestations	Yes	No
- Thrombocytopenia (less than or equal to 100000 per mm3)	Yes	No
- Haemoconcentration (haemotocrit increased by 20% or more)	Yes	No
- Evidence of plasma leakage (i.e. pleural effusion, ascites or hypoproteinaemia etc)	Yes	No
- Evidence of the Dengue Shock Syndrome (DSS) confirmed by a consultant physician	Yes	No
- hypotension (< 80 mmHg) or narrow pulse pressure (⩽ 20 mmHg)	Yes	No
- evidence of tissue hypoperfusion such as cold, clammy skin, oliguria or a metabolic acidosis	Yes	No
Please complete Question 8 to 11 if the patient's condition is on: **Hospitalisation of life assured's child due to Phototherapy for severe neonatal jaundice**		
8. Did the child received phototherapy treatment for neonatal jaundice?	Yes	No
9. Was the phototherapy received on an inpatient basis?	Yes	No
10. Please state the period when the newborn received inpatient phototherapy: _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)		
11. Was the total serum bilirubin level > 250 µ mol/L Please state the reading and provide us with a copy of the laboratory result _____	Yes	No

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

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

Please complete Question 12 if the patient's condition is on: Hospitalisation of life assured's child due to Pneumonia		
12. Was the child admitted for pneumonia? Please state the period of confinement (including ICU and HDU ward, if any): _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY) Period in ICU: _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY) Period in HDU: _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
Please complete Question 13 to 15 if the patient's condition is on: Hospitalisation of life assured's child due to Severe measles		
13. Was the patient admitted for measles?	Yes	No
14. Please state the period of admission: _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)		
15. Did the condition result in any of the following complications:		
- Pneumonia	Yes	No
- Encephalitis	Yes	No
- Convulsions	Yes	No
- Hepatitis	Yes	No
Please complete Question 16 to 18 if the patient's condition is on: Hospitalisation of life assured's child due to Severe Hand, Foot and Mouth Disease (HFMD)		
16. Was the patient admitted for Hand, Foot and Mouth Disease? If yes, please state the period of admission _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No

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

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

17. Please provide us a copy of the laboratory report showing positive isolation of the causative virus.		
18. Was the Hand, Foot and Mouth Disease associated with any of the following complications:		
- Encephalitis	Yes	No
- Myocarditis	Yes	No
Please complete Question 19 to 21 if the patient's condition is on: Hospitalisation of life assured's child due to Chikungunya fever		
19. Was the patient admitted for Chikungunya fever? If yes, please state the period of admission _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
20. Please provide us a copy of the laboratory report showing positive isolation of the causative virus.		
21. Was the condition associated with any of the following complications:		
- Myocarditis	Yes	No
- Ocular disease (uveitis, retinitis)	Yes	No
- Hepatitis	Yes	No
- Severe bullous lesions	Yes	No
- Neurological disease such as meningoencephalitis, Guillain-Barre syndrome, myelitis or cranial nerve palsies	Yes	No
Please complete Question 22 to 24 if the patient's condition is on: Hospitalisation of life assured's child due to Typhoid fever		
22. Was the patient admitted for typhoid fever? If yes, please state the period of admission _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No

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

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

23. Was the diagnosis confirmed on:		
- Positive culture of Salmonella typhi from blood (by the Widal test (titer ⩾ 1/320) and/ or the Tubex test (+4))	Yes	No
- Stool sample	Yes	No
Please provide us a copy of the laboratory report.		
24. Was the condition associated with any of the following complications:		
- Intestinal bleeding	Yes	No
- Intestinal perforation	Yes	No
- Severe neuropsychiatric symptoms namely delirium or psychosis	Yes	No
Please complete Question 25 to 27 if the patient's condition is on: Hospitalisation of life assured's child due to Rabies		
25. Was the patient admitted for rabies? If yes, please state the period of admission _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
26. Did the patient present with any of the following symptoms:		
- Muscle fasciculations	Yes	No
- Delirium	Yes	No
- Psychosis	Yes	No
- Seizures	Yes	No
- Aphasia	Yes	No
27. Did the patient receive prophylactic post exposure vaccination?	Yes	No

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

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

Please complete Question 28 to 30 if patient's condition is on: Hospitalisation of life assured's child due to Zika		
28. Was the child admitted to hospital as a result of Zika? If yes, please state the period of confinement _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
29. Was the diagnosis of Zika virus infection confirmed on positive isolation of the virus?	Yes	No
30. Was the hospitalization due to complications of Zika (eg. microcephaly)?	Yes	No
If yes, please provide details.		
Please complete Question 31 to 33 if the patient's condition is on: Hospitalisation of life assured's child due to MERS-CoV		
31. Was the patient admitted for MERS-CoV? If yes, please state the period of admission _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
32. Was the diagnosis of MERS-CoV detected via reverse-transcription polymerase chain reaction (RT-PCR) assay?	Yes	No
33. Were there confirmation from:		
- At least two specific genomic targets?	Yes	No
- A single positive target with sequencing of a second target	Yes	No

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

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

Please complete Question 34 to 35 if the patient's condition is on: Hospitalisation of life assured's child due to Ebola		
34. Was the patient admitted for Ebola? If yes, please state the period of admission _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
35. Was the diagnosis of Ebola confirmed on positive isolation of the virus?	Yes	No
Please complete Question 36 to 39 if the patient's condition is on: Hospitalisation of life assured's child due to SARS		
36. Was the patient admitted for SARS? If yes, please state the period of admission _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
37. Was the diagnosis of SARS confirmed on positive isolation in cell culture of SARS-CoV from a clinical specimen?	Yes	No
38. Was the diagnosis of SARS detected via reverse-transcription polymerase chain reaction (RT-PCR) assay?	Yes	No
39. Were there confirmation from:		
- At least two clinical specimens from different sources?	Yes	No
- At least two clinical specimens collected from the same source on 2 different days?	Yes	No
Please complete Question 40 to 41 if the patient's condition is on: Hospitalisation of life assured's child due to Influenza A – Avian Influenza (H7N9 and A(H5N1)		
40. Was the patient admitted for Avian Influenza? If yes, please state the period of admission _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No

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

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

41. Was the diagnosis of Avian Influenza confirmed on positive isolation of the virus?	Yes	No
Please complete Question 42 to 43 if the patient's condition is on: Hospitalisation of life assured's child due to Nipah virus encephalitis		
42. Was the patient admitted for Nipah virus encephalitis? If yes, please state the period of admission _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
43. Was the diagnosis of Nipah virus encephalitis confirmed on positive isolation of the virus via reverse transcriptase polymerase chain reaction (RT-PCR)?	Yes	No
Please complete Question 44 to 45 if the patient's condition is on: Hospitalisation of life assured's child due to Japanese encephalitis		
44. Was the patient admitted for Japanese encephalitis? If yes, please state the period of admission _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
45. Was the diagnosis of Japanese encephalitis confirmed on positive culture from cerebrospinal fluid?	Yes	No
Please complete Question 46 to 48 if the patient's condition is on: Hospitalisation of life assured's child due to Creutzfeldt-Jakob disease		
46. Was the patient admitted for Creutzfeldt-Jakob disease? If yes, please state the period of admission _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
47. Was the condition accompanied by any of the following signs and symptoms:		
- Uncontrolled muscular spasm or tremor	Yes	No
- Severe progressive dementia	Yes	No

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

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

- Cerebellar dysfunction	Yes	No
- Athetosis	Yes	No
48. Was the diagnosis confirmed on the following? Please provide copy of the laboratory reports.		
- Electroencephalography (EEG)	Yes	No
- Cerebrospinal fluid (CSF) findings	Yes	No
- Computed Tomography (CT) scan	Yes	No
- Magnetic Resonance Imaging (MRI)	Yes	No
Please complete Question 49 to 50 if the patient's condition is on: Hospitalisation of life assured's child due to Malaria		
49. Was the patient admitted for Malaria? If yes, please state the period of admission _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
50. Was the diagnosis confirmed with light microscopy with a parasitaemia of ⩾100,000 parasites/ mL of blood?	Yes	No
Please complete Question 51 to 53 for Hospital care accelerator (Life assured's Child)		
51. Please state the period of admission. _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)		
52. Was the patient admitted to the neonatal intensive care unit or intensive care unit for at least three days?	Yes	No
53. Please state the period of admission in the NICU or ICU ward (if any). _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)		

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

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

Please complete Question 54 if the patient's condition is on: Hospitalisation of life assured (mother) due to Zika		
54. Was the life assured (mother) admitted to hospital as a result of Zika during the term of her pregnancy? If yes, please state the period of confinement _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)	Yes	No
Please complete Question 55 to 60 if patient's condition is on: Hospitalisation of life assured (mother) due to Inpatient Psychiatric Treatment		
55. Was the patient admitted to hospital for peripartum psychosis?	Yes	No
56. Please state the period of admission. _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)		
57. If no, please state the cause of admission and when was it diagnosed? _____		
58. Was the diagnosis made based on DSM-5 criteria?	Yes	No
59. Was the diagnosis confirmed by a psychiatrist?	Yes	No
60. Please state the period of admission. _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)		

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

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

Please complete Question 61 to 64 if patient's condition is on: Hospitalisation of life assured (mother) due to Post-natal anaemia		
61. Was the patient admitted to hospital for treatment of postpartum anaemia?	Yes	No
62. Please state the period of admission. _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)		
63. Did the patient receive blood transfusion during the admission?	Yes	No
64. Was the patient's Hb level prior to transfusion <70 g/l? What was the patient's Hb level prior to transfusion? Please provide copy of the laboratory report. _____	Yes	No
Please complete Question 65 to 67 if patient's condition is on: Hospitalisation of life assured (mother) due to Puerperal Pyrexia		
65. Was the patient admitted to the Intensive care unit for treatment of infection, causing puerperal pyrexia?	Yes	No
66. Please state the period of admission. _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)		
67. Did the patient present with any of the following symptoms:		
- High fever;	Yes	No
- Abdominal pain;	Yes	No
- Hypotension; and	Yes	No
- Shock	Yes	No

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

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

Please complete Question 68 to 71 if patient's condition is on: Hospitalisation of life assured (mother) due to Pulmonary Embolism		
68. Was the patient admitted to hospital for peripartum psychosis?	Yes	No
69. Please state the period of admission. _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)		
70. Did the patient present with any of the following symptoms:		
- Chest pain;	Yes	No
- Difficulty in breathing; and	Yes	No
- Low arterial oxygen level;	Yes	No
71. Were any of the following tests done to confirm the diagnosis?		
- D-dimer test;	Yes	No
- CT pulmonary angiography	Yes	No
- Ventilation perfusion scan	Yes	No
Please provide us with a copy of the laboratory reports.		
Please complete Question 72 to 74 if patient's condition is on: Hospitalisation of life assured (mother) due to Repair of 4th degree perineal tear		
72. Did the patient sustain a fourth-degree perineal tear during childbirth?	Yes	No
73. Was surgery done to repair the tear?	Yes	No
74. Please state the date the surgical repair was done. _____(DD/MM/YYYY)		

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

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

Please complete Question 75 to 78 if patient's condition is on: Hospitalisation of life assured (mother) due to Septic pelvic thrombophlebitis		
75. Did the patient suffer from phlebitis due to infected blood clot?	Yes	No
76. Was the diagnosis supported by ultrasound, CT scan or MRI? Please provide us with a copy of the scan report.	Yes	No
77. Did the patient receive inpatient treatment with antibiotics and anticoagulation?	Yes	No
78. Please state the period of admission. _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)		
Please complete Question 79 to 81 if patient's condition is on: Hospitalisation of life assured (mother) due to Surgical Site infection following caesarian section		
79. Did the patient suffer from infection of caesarean section surgical site following childbirth?	Yes	No
80. Did she receive inpatient treatment with incision and drainage at the surgical site and intravenous antibiotics?	Yes	No
81. Please state the period of admission due to the infection. _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)		
Please complete Question 82 to 87 if patient's condition is on: Hospitalisation of life assured (mother) due to Uterine infection or transfusion due to retained placenta following childbirth		
82. Did the patient suffered from complications of retained placenta after a term vaginal delivery?	Yes	No
83. Did she receive inpatient treatment with intravenous antibiotics or a transfusion for excessive blood loss?	Yes	No

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

84. Please state the period of admission. _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)		
85. Has the patient undergone surgical removal of the retained placenta?	Yes	No
86. Please state the date of surgical removal _____(DD/MM/YYYY)		
87. Did the patient received surgery or other treatment for incomplete uterine evacuation following miscarriage or termination of pregnancy during the admission? Please provide details of the surgery, surgery date or treatment:	Yes	No
Please complete Question 88 to 91 if patient's condition is on: Hospitalisation of life assured (mother) due to Complications of Lactational Mastitis		
88. Did the patient suffer from lactational mastitis?	Yes	No
89. Did she receive inpatient treatment?	Yes	No
90. What was the treatment received?		
- Incision and drainage surgery	Yes	No
- Simple needle aspiration	Yes	No
- Others: please specify _____		
91. Please state the period of admission. _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)		

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

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

Please complete Question 92 to 96 for Hospital care accelerator (Life Assured)		
92. Was the patient admitted to hospital during her pregnancy or post-delivery?	Yes	No
93. What was the gestation period when the patient was admitted?	Yes	No
94. Please state the period of admission. _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)		
95. Was the patient admitted to the ICU ward?	Yes	No
96. Please state the period of admission in the ICU ward (if any). _____ to _____ (DD/MM/YYYY) (DD/MM/YYYY)		
SECTION III		
1. Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? If yes, please provide the date of HIV/ AIDS diagnosis. _____(DD/MM/YYYY)	Yes	No
2. Is the diagnosis related to the consumption of any 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.		

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

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

4. Was this pregnancy conceived through any fertility treatment? (please tick as applicable) a) In-vitro fertilization (IVF) ☐ b) Intracytoplasmic sperm injection (ICSI) ☐ c) Intrauterine insemination (IUI) ☐ d) Intracervical insemination (ICI) ☐ e) Others: ☐ Please specify _____ If yes, please state the number of foetus conceived: _____	Yes	No
5. Was the child conceived through a pregnancy, which carried 3 or more babies in a single pregnancy?	Yes	No
SECTION IV		
1. Is the patient suffering from any significant medical condition? If yes, please provide the following information:	Yes	No
a) Date of diagnosis _____(DD/MM/YYYY) b) Name and practice address of the doctor who had diagnosed/ treated the patient.		
2. 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?		
Name and Signature of the Medical Specialist who filled up **Section 2**	Date	
Practice Stamp of the Medical Specialist		

PART 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.

Prudential Assurance Company Singapore (Pte) Limited
Postal Address: Robinson Road P.O. Box 492 Singapore 900942
Telephone: 1800 333 0333 Fax: 6734 9555
Part of Prudential Corporation plc Reg. No 199002477Z