CRISIS COVER CLAIM FORM

1. **Angioplasty and Other Invasive Treatment for Coronary Artery**
2. **Coronary Artery By-pass Surgery / Keyhole Coronary Bypass Surgery / Coronary Artery Arthrectomy / Transmyocardial Laser Revascularisation / Enhanced External Counterpulsation Device Insertion/ Port access cardiac surgery**
3. **Heart Attack of Specified Severity / Cardiac Pacemaker Insertion / Pericardectomy / Cardiac Defibrillator Insertion / Early Cardiomyopathy / Severe Cardiomyopathy**
4. **Other Serious Coronary Artery Disease / Early Stage Other Serious Coronary Artery Disease / Intermediate Stage Other Serious Coronary Artery Disease**
5. **Major Organ (Heart) Transplantation**

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. The Company 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.

SECTION 1

(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.

☐ Angioplasty and Other Invasive Treatment for Coronary Artery	☐ Keyhole Coronary Bypass Surgery	☐ Cardiac Defibrillator Insertion
☐ Coronary Artery By-pass Surgery	☐ Coronary Artery Arthrectomy	☐ Severe Cardiomyopathy
☐ Heart Attack of Specified Severity	☐ Transmyocardial Laser Revascularisation	☐ Early Cardiomyopathy
☐ Other Serious Coronary Artery Disease	☐ Enhanced External Counterpulsation Device Insertion	☐ Intermediate Stage Other Serious Coronary Artery Disease
☐ Major Organ (Heart) Transplantation	☐ Cardiac Pacemaker Insertion	☐ Early Stage Other Serious Coronary Artery Disease
☐ Port access cardiac surgery	☐ Pericardectomy	

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		YYYY
4. Date when Life Assured first consulted a doctor for the above signs or symptoms		DD		MM		YYYY

5. Has Life Assured previously suffered from or received treatment for a similar or related illness / injury?	Yes	No

If yes, please give details.

6. 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

7. 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

8. 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**. T&Cs apply (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 policyholder'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 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 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

SECTION 2 - MEDICAL SPECIALIST REPORT

1. Angioplasty and Other Invasive Treatment for Coronary Artery
2. Coronary Artery By-pass Surgery / Keyhole Coronary Bypass Surgery / Coronary Artery Arthrectomy / Transmyocardial Laser Revascularisation / Enhanced External Counterpulsation Device Insertion/ Port access cardiac surgery
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5. Major Organ (Heart) Transplantation

(To be completed by the Life Assured's attending medical specialist)

Name of Specialist		MCR No.	
Field of Specialty			
Name of Medical Institution			

Part I

1. Date when patient first consulted you for the condition?		DD		MM		YYYY
2. When was the last consultation?		DD		MM		YYYY
3. What were the presenting symptoms when you first saw the patient?							
4. When did the above symptoms first present?		DD		MM		YYYY
5. Please provide exact diagnosis.							
6. What is/are the underlying cause(s)?							
7. Date of diagnosis		DD		MM		YYYY
8. Date when patient / patient's next of kin first informed of the diagnosis.		DD		MM		YYYY

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

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? Please circle.						Yes	No
11. If Yes to Question 10, over what period do your records extend?	From (DD/MM/YYYY)			To (DD/MM/YYYY)			
12. If you are not the first doctor who diagnosed the patient with this condition, please provide:							
a. Name and 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		YYYY	
c. When was the referral made for the patient to see you?		DD		MM		YYYY	
d. What was the reason for referral to see you? Please attach a copy of the referral letter.							
e. Please provide name and address of referral doctor.							
PART II							
1. Please provide details of the initial episode below:-							
a. Date of initial episode.		DD		MM		YYYY	
b. Nature of episode.							
c. Duration of acute symptoms.							
d. Date of return to normal activities.		DD		MM		YYYY	
2. Was there evidence of death of heart muscle due to obstruction of blood flow (Acute Myocardial Infarction)? Please circle.						Yes	No
3. Was there history of typical chest pain? Please circle.						Yes	No
4. Was there any sign of ECG changes evident of new death of heart muscle due to obstruction of blood flow (Acute Ischemic Heart Disease)? Please circle.						Yes	No

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

5. Were there new ECG changes with development of ST elevation or depression? Please circle.	Yes	No
6. Were there new ECG changes with development of T wave inversion? Please circle.	Yes	No
7. Were there new ECG changes with development of pathological Q waves? Please circle.	Yes	No
8. Were there new ECG changes with development of left bundle branch block? Please circle.	Yes	No

If Yes to the above Question 2 to 8, please elaborate:

Date of ECG result that you have based on to derive the diagnosis of Acute Myocardial Infarction or Acute Ischemic Heart Disease.	Please describe the ECG changes indicative of new death of heart muscle due to obstruction of blood flow (Acute Myocardial Infarction or Acute Ischemic Heart Disease).

9. Was there elevation of cardiac enzyme Troponin (T or I) evident of death of heart muscle due to obstruction of blood flow (Acute Myocardial Infarction)? Please circle.	Yes	No

10. If Yes to Question 9, please state the series of elevated cardiac enzyme Troponin (T or I) and its respective date of blood test result you have based on.	11. If No to Question 9, please provide the justification based on to confirm the diagnosis of heart muscle death due to obstruction of blood flow without elevation in cardiac enzyme Troponin (T or I).

12. Was the rise in cardiac Troponin (T or I) measured at 0.5ng/ml and above? Please circle.	Yes	No
13. Was the elevation of cardiac enzyme Troponin (T or I) following an intra-arterial cardiac procedure? Please circle.	Yes	No

If Yes to Question 13, please state the name and date of intra-arterial cardiac procedure patient has received.

14. Was there elevation of cardiac enzyme CK-MB evident of death of heart muscle due to obstruction of blood flow (acute Myocardial Infarction)? Please circle.	Yes	No

15. If Yes to Question 14, please state the date and findings of blood test result that you have based on.	16. If No to Question 14, please provide the justification you have based on to confirm the diagnosis of heart muscle death due to obstruction of blood flow without elevation in cardiac enzyme CK-MB.

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

17. Was the elevation of cardiac enzyme CK-MB following an intra-arterial cardiac procedure? Please circle.	Yes	No
If Yes to Question 17, please state the name and date of intra-arterial cardiac procedure patient has received.		
18. Was there diagnostic elevation of any other cardiac enzymes? Please circle.	Yes	No

If Yes to Question 18, please elaborate.

Type of cardiac enzymes test	Date of test (DD/MM/YYYY)	Description of the result

19. Was there left ventricular ejection fraction less than 50%? Please circle.	Yes	No
If Yes to Question 19, please state date of test, the results, and to attach a copy of the diagnostic report.		
20. Was there imaging evidence of new loss of viable myocardium? Please circle.	Yes	No
21. Was there imaging evidence of new regional wall motion abnormality? Please circle.	Yes	No
If Yes to Question 20 & 21, please provide evidence of the imaging reports.		

22. Please indicate which major coronary arteries were occluded and its percentage of stenosis:

Major Coronary Artery	Percentage of Stenosis
Left main stem	
Left anterior descending	
Left circumflex	
Right coronary artery	

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

23. Is any form of coronary artery surgery required to treat patient's coronary artery disease? Please circle.	Yes	No

Type of Surgery	Has patient undergone this surgery? (Please circle)		Date patient was recommended for this surgery (DD/MM/YYYY)	Date surgery have been performed (DD/MM/YYYY)
Angioplasty	Yes	No		
Other Invasive Treatment for Coronary Artery (please specify):	Yes	No		
Port access procedure to correct narrowing or blockage of coronary artery(ies)	Yes	No		
Open-chest Coronary Artery By-pass Surgery	Yes	No		
Minimally Invasive Direct Coronary Artery Bypass Surgery	Yes	No		
Keyhole Coronary Bypass Surgery (Endoscope)	Yes	No		
Coronary Artery Arthrectomy	Yes	No		
Transmyocardial Laser Revascularisation	Yes	No		
Enhanced External Counterpulsation	Yes	No		

24. If NONE OF THE ABOVE cardiac procedure listed in Question 23 is applicable, please provide the following details:

Name & Type of Surgery	Date patient was recommended for this surgery (DD/MM/YYYY)	Date cardiac surgery was performed (DD/MM/YYYY)

25. Was a cardiac pacemaker inserted? Please circle.					Yes		No
26. Is the insertion of cardiac pacemaker permanent? Please circle.					Yes		No
27. Date the insertion of cardiac pacemaker was performed.		DD			MM		YYYY
28. Was a cardiac defibrillator inserted? Please circle.					Yes		No

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

29. Is the insertion of cardiac defibrillator permanent? Please circle.						Yes	No
30. Date the insertion of cardiac defibrillator was performed.		DD		MM		YYYY	
31. Was there any other method of treatment, other than cardiac defibrillator or cardiac pacemaker, which could have been used to treat patient's cardiac arrhythmia? Please circle.						Yes	No
If Yes to Question 31, please state the following:							
To specify the name of the alternative method of treatment.		To explain the basis why this alternative method of treatment was not performed to treat patient's cardiac arrhythmia.					
32. Date when patient was diagnosed with Cardiomyopathy.		DD		MM		YYYY	
33. What was the underlying cause of patient's Cardiomyopathy?							
34. Is the patient's condition of Cardiomyopathy directly related to alcohol misuse? Please circle.						Yes	No
If Yes to Question 34, please provide details of alcohol consumption, including frequency of consumption, amount of consumption, duration, and types of alcohol consumed.							
35. Has the cardiomyopathy resulted in permanent and irreversible physical impairments of at least Class IV of the New York Association (NYHA) classification of Cardiac Impairment?						Yes	No
36. Has the patient's diagnosis of Cardiomyopathy resulted in any physical impairment which fulfills the New York Heart Association (NYHA) classification of Cardiac Impairment? Please circle.						Yes	No
Please provide us with the details 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

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

37. Was the NYHA classification determined by the provision of maximal medical therapy according to treatment practice guidelines for at least 6 months?					Yes		No
38. Was the diagnosis of Cardiomyopathy supported by echocardiographic findings of compromised ventricular performance? Please provide us with a copy of the echocardiogram report.					Yes		No
39. Date when patient was diagnosed with Pericardial Disease.		DD			MM		YYYY
40. Was any form of surgical treatment performed to treat patient's pericardial disease? Please circle.					Yes		No

If Yes to Question 40, please state if the surgery has been performed using any of the listed cardiac surgery below:

Type of Surgery	Has patient undergone this surgery? (Please circle)		Date cardiac surgery was performed (DD/MM/YYYY)
Pericardectomy	Yes	No	
Other surgical procedure requiring keyhole cardiac surgery as a result of pericardial disease	Yes	No	

41. What is the exact date of transplant?		DD			MM		YYYY
42. Was the transplant resulted from an irreversible end stage failure of the heart? Please circle.					Yes		No
43. Was the surgery performed on the heart and does not involve transplantation? Please circle.					Yes		No

44. What is the prognosis?

PART III

1. Please circle your reply to Question (a) to (e) below, if patient's condition or surgery performed in any way related to 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 to any of Question 1 above, please provide the following details and also attach a copy of the test result.

Exact diagnosis	Date of diagnosis (DD/MM/YYYY)	Name and practice address of treating doctor

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

2. Has the patient previously suffered from raised cholesterol, hypertension, heart attack, heart murmur, mitral valve prolapse or other heart valve disorders, chest discomfort or pain, disease of or any other disorders of the heart or blood vessels? Please circle. If Yes, please provide the following details:				Yes	No
Diagnosis	**Date of diagnosis**	**Date when patient was informed of diagnosis**	**Name and date of treatments**	**Name and address of treating doctor**	
3. Is there anything in patient's medical history which would have increased the risk of having heart disease? Please circle.				Yes	No
If Yes to Question 3, please state the details:					
4. Does the patient have or ever had any other significant health condition? Please circle. If Yes, please provide the following details:				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 **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.

1. ECG readings
2. Coronary Angiogram
3. Laboratory results evident of diagnostic elevation of cardiac enzymes CKMB, Troponin T or I
4. Operation report (if surgery has been performed)