CRISIS COVER CLAIM FORM

Crisis Care Accelerator

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 [√] in the appropriate box for the respective category of benefit and to state the type of illness / medical conditions you are claiming on the above policy(ies).

☐ **Crisis Care Accelerator**

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. Please provide the following details accordingly if the consultation was due to illness or accident.

If consultation was for illness, describe fully the nature and extent of illness in terms of its diagnosis and treatment received.	If consultation was due to accident, describe fully the date of accident, how and where did the accident occur.		
	Was the accident reported to the police?	Yes	No
	If yes, please provide: • the name of police officer and police station at which the accident was reported; and • a copy of the police report.		

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

If yes, please give details.

7. 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

8. 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

9. 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**. 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 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
CRISIS CARE ACCELERATOR
(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
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?	Yes	No
11. If Yes, 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 practice 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

Name and Signature of the Medical Specialist who filled up **Section 2**	Date

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.

PART II

1. Did the patient underwent surgery for any of the following vital organs as a result of illness or an accident?

a. Heart	Yes	No
b. Lung	Yes	No
c. Brain	Yes	No
d. Kidney	Yes	No
e. Liver	Yes	No

2. If the surgery was performed as a result of an illness, please provide details of the illness.

Date of diagnosis of illness: _____ (DD/MM/YYYY)

3. If the surgery was performed as a result of an accident, please provide details of how the accident happened.

Date of accident: (DD/MM/YYYY)

4. Please state the nature of the surgery performed.

Date surgery was performed: (DD/MM/YYYY)

5. Was the patient admitted to the Intensive Care Unit (ICU) as a result of the surgery, for at least three continuous days.			Yes	No
6. Please state the period that the patient was hospitalised.	From	(DD/MM/YYYY)	To	(DD/MM/YYYY)
7. Please state the period that the patient was in ICU	From	(DD/MM/YYYY)	To	(DD/MM/YYYY)

PART III

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?

Name and Signature of the Medical Specialist who filled up **Section 2**	Date

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

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 patient mentally incapacitated?	Yes	No
2. Is the patient's condition or surgery performed in any way related 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 for any of the above, please provide the following details and also attach a copy of the test result.		
f. Please indicate the diagnosis date.	DD MM YYYY	
g. Name and practice address of the doctor who first diagnosed the patient with HIV, AIDS, drug abuse, alcohol abuse or congenital anomaly.		
3. Has the patient previously suffered from the condition described above or any related illness? If Yes, please provide the details below:	Yes	No

Diagnosis	Date of diagnosis	Date when patient was informed of diagnosis	Name and date of treatments	Name and address of treating doctor

4. Is there anything in patient's medical history which would have increased the risk of his/her condition?	Yes	No
If Yes, please state the details.		
5. Does the patient have or ever had any other significant health condition? If Yes, please provide:	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.