PruHospital Income Claim Form

(To be completed by Claimant)

1. The Company does not admit liability by the mere issuance of this form.

2. Please complete and return this form together with the Medical Report and the original Medical Certificate, Original bills and receipt to the Company.

Important Note: 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.

Personal Particulars

Name of Claimant	NRIC Number	Occupation	Policy Number

Address	Age	Telephone

Details of Claim

Benefit Plan Type

☐ Plan 1 ☐ Plan 2 ☐ Plan 3

Types of Claim

☐ Daily Hospital Income

☐ Daily Hospital Overseas Income

☐ Daily Intensive Care Unit Benefit

☐ Compassionate Boarding Fee

☐ Hospital Expenses (Illness) Reimbursement

☐ Hospital Expenses (Accident) Reimbursement

☐ Discharge Transportation Grant

☐ Recuperation Grant

☐ Temporary Disablement Benefit

☐ Death

☐ 24-Hour Worldwide Accidental Emergency Assistance Service

Details of Illness / Injury

1. What is the cause of illness / injury

☐	Illness	Date symptoms first started	
☐	Accident	Date and Time of Accident	

2. Was there a police report Yes ☐ No ☐
(If Yes, please provide a copy.)

3. Describe in detail the nature of the illness / injury. If the condition is caused by an accident, please give details on the accident.

Please go to the benefits that you are claiming for and fill in accordingly

1. Daily Hospital Income Benefit

Date of hospitalization: From _____ to _____

Have you suffered this or a similar condition or a recurrence of a previous illness or injury

☐ Yes ☐ No If Yes, please specify _____

Date of first consultation of the injury/illness _____

Date in which you first noticed symptoms of condition _____

2. Daily Hospital Overseas Income (Applicable to hospital in the USA, Canada, Switzerland, Japan or member of the European Union)

Country visited _____ Duration of visit _____

Purpose_____

State the country of hospital _____

Date of hospitalization: From _____ to _____

3. Daily Intensive Care Unit Benefit

Number of ICU stays: _____

4. Compassionate Boarding Fee

Names of Boarders _____ relationship _____

Date of boarding: From _____ to _____

5. Hospital Expenses (Illness) Reimbursement

Medical Expenses _____

Are you claiming Medical Expenses from other sources Yes ☐ No ☐

If yes, please provide details of claim:

Name of Company	Nature of Claim	Amount Claimed	Policy Number (if applicable)

6. Hospital Expenses (Accident) Reimbursement

Medical Expenses _____

Are you claiming Medical Expenses from other sources? Yes ☐ No ☐

If yes, please provide details of claim:

Name of Company	Nature of Claim	Amount Claimed	Policy Number (if applicable)

7. Discharge Transportation Grant ☐

8. Recuperation Grant ☐

9. Temporary Disablement Benefit

Date of medical certificates : From _____ to _____

10. Death

Date of Death : _____

Cause of Death : _____

Name of Claimants : _____

_____

Declaration

I hereby declare that all the information given by me in this form, is to the best of my knowledge and belief, true and complete. I authorise Prudential Assurance Company (Pte) Limited ("Prudential") to:

a) seek medical information from any doctor who, at any time, has attended to the life assured concerning anything that affects his/her physical or mental health;
b) seek information from any insurance office to which an insurance proposal has been made;
c) seek information from any other sources (including employer, government authorities) in connection with this claim; and
d) disclose information including medical information about me to other insurers, reinsurers or other third parties assisting with my claim,

for the assessment of my claim.

I understand and agree that Prudential should have full access to the information stated above and a photographic copy of this authorisation shall be as valid as the original.

Signature of Claimant:

Date: