PRUDENTIAL

PruCustomer Line: 1800 -333 0 3333

CRISIS COVER CLAIM FORM

SPECIAL BENEFIT (Special Medical Conditions and Juvenile Medical Conditions)

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.

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)

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 Special and Juvenile Medical Conditions you are claiming on the above policy(ies).

Special Medical Conditions	Juvenile Medical Conditions	
☐ Diabetic Complications	☐ Glomerulonephritis with Nephrotic Syndrome	☐ Haemophilia A and Haemophilia B
☐ Osteoporosis with Fractures	☐ Insulin Dependent Diabetes Mellitus	☐ Kawasaki Disease with heart complications
☐ Severe Rheumatoid Arthritis	☐ Osteogenesis Imperfecta	☐ Rheumatic Fever with valvular impairment
☐ Benign Tumor requiring surgical excision	☐ Still's Disease	☐ Wilson's Disease
	☐ Autism Spectrum Disorder (ASD)	☐ Attention-Deficit Hyperactivity Disorder (ADHD)
	☐ Dyslexia	☐ Hand, Foot and Mouth Disease

DETAILS OF ILLNESS / MEDICAL CONDITION

2. Describe fully the signs or symptoms for which Life Assured has consulted doctor or received treatment.

C030221

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

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

10. Please tick one of the boxes below to indicate your preferred payment method.

☐ Cheque to be mailed directly to Policyowner address

☐ Cheque to be collected by Prudential Financial Consultant

☐ Cheque to be mailed directly to Prudential Financial Consultant at Agency

Name and Contact No. of your appointed Prudential Financial Consultant:

☐ Direct credit of proceeds into Policyowner's SGD dollar bank account
(*if you select this payment mode, you need to* ***submit*** *a copy of the bank book or bank statement stating account holder name and number*)

Name of Bank	Branch of Bank	Bank Account Number	Name of Account Holder

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 investigating my claim(s) arising under the Policy and such other purposes ancillary or related to the assessing, processing and investigating my claim(s) and administering of the Policy, (ii) customer servicing, statistical analysis, conducting customer due diligence, reporting to regulatory or supervisory authorities, auditing and recovery of any debts owing to PACS under this Policy, (iii) storage and retention, (iv) meeting requirements of prevailing internal policies of PACS, and (v) 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)**") pertaining to this claim, to disclose, release, transfer and exchange any information to 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, all 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 any person(s) or organisation(s) listed in above, 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 assisting with my claim 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, I represent and warrant that I have obtained the consent of the Individual for PACS, its officers, employees, representatives or distribution partners 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's 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 General Data Protection Regulation ("GDPR") Privacy Notice (which is available at https://www.prudential.com.sg/GDPR-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 II - MEDICAL SPECIALIST REPORT

SPECIAL BENEFIT (Special Medical Conditions and Juvenile Medical Conditions)

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

Please tick [√] in the appropriate box and complete the relevant sections in respect to the medical conditions claims. Please submit ONLY the relevant sections to us upon completion.

	Special Medical Conditions	Sections to completed
☐	Diabetic Complications	1, 2, 18
☐	Osteoporosis with Fractures	1, 3, 18
☐	Severe Rheumatoid Arthritis	1, 4, 18
☐	Benign Tumor requiring surgical excision	1, 5, 18

	Juvenile Medical Conditions	Sections to completed
☐	Glomerulonephritis with Nephrotic Syndrome	1, 6, 18
☐	Haemophilia A and Haemophilia B	1, 7, 18
☐	Insulin Dependent Diabetes Mellitus	1, 8, 18
☐	Kawasaki Disease with heart complications	1, 9, 18
☐	Osteogenesis Imperfecta	1, 10, 18
☐	Rheumatic Fever with valvular impairment	1, 11, 18
☐	Still's Disease	1, 12, 18
☐	Wilson's Disease	1, 13, 18
☐	Autism Spectrum Disorder (ASD)	1, 14, 18
☐	Dyslexia	1, 15, 18
☐	Attention-Deficit Hyperactivity Disorder (ADHD)	1, 16, 18
☐	Hand, Foot and Mouth Disease with severe complications	1, 17, 18

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

SECTION 1 : GENERAL INFORMATION

1. Date when patient first consulted you for the condition?		DD		MM		YY
2. When was the last consultation?		DD		MM		YY
3. What were the presenting symptoms when you first saw the patient?						
4. When did the above symptoms first present?		DD		MM		YY
5. Please provide exact diagnosis:						

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

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

6. What is/are the underlying cause(s)?						
7. Date of diagnosis		DD		MM		YY
8. Date when patient/patient's next of kin first informed of the diagnosis.		DD		MM		YY
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, over what period do your records extend?		From (dd/mm/yy)			To (dd/mm/yy)	
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		YY
c. When was the referral made for the patient to see you?		DD		MM		YY
d. What was the reason for referral to see you? Please attach a copy of the referral letter.						

SECTION 2 : DIABETIC COMPLICATIONS

1. When was the diabetes diagnosed?		DD		MM		YY
2. Please provide a description of the extent of patient's diabetes.						
3. What treatment has been prescribed?						
4. Name and practice address of the doctor that the patient is seeing for management of his/her diabetes.						
5. Please give details of recent blood sugar levels.						

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

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

6.	Is there evidence of diabetic retinopathy? If Yes, please provide the following:					Yes	No
	a. Please circle which of the eye is affected by diabetic retinopathy?			**Left Eye**		**Right Eye**	
	b. Using the Snellen eye chart, what is the best possible corrected visual acuity of both eyes?			Left eye		Right eye	
	c. Does patient require laser treatment for his/her diabetic retinopathy?					Yes	No
	i. If laser treatment had been given, please state the date(s) of such treatment.		DD		MM		YY
	d. Is such treatment absolutely necessary?					Yes	No
	If No, please specify what alternative treatment is available for the patient's condition?						
	e. Please provide results of investigations done and attach copies of the fluorescent fundus angiography report.						
7.	Is there evidence of diabetic nephropathy? If Yes, please provide the following:					Yes	No
	a. Is there decreased renal function of less than eGFR less than 30 ml/min/1.73m^2?					Yes	No
	Please provide the eGFR readings, including dates of assessment.						
	b. Is there ongoing proteinuria greater than 300 mg/24 hours					Yes	No
	Please provide the proteinuria readings, including dates of assessment.						
	c. Please provide the results of investigations done and attach copies of renal function test and urinalysis reports.						
8.	Has the patient undergo any amputation due to diabetes? If Yes, please provide the following:					Yes	No
	a. Please state the underlying cause for the amputation.						

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

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

b. Please state the site/area of amputation.						
c. Please state name and type of surgery patient has undergone.						
d. Please state exact date of surgery?		DD		MM		YY
e. Please state the name and address of hospital where the surgery was performed.						

SECTION 3 : OSTEOPOROSIS WITH FRACTURES

1. Is there evidence of osteoporosis with a bone density reading T-score of less than -2.5?	Yes	No
2. Please provide results of patient's bone density T-score readings, including dates of assessment?		
3. Is there osteoporotic fractures involving femur, wrist or vertebrae? If Yes, please provide the following:	Yes	No
a. Was there history of three or more osteoporotic fractures?	Yes	No
b. Please specify the bodily site of fracture and the corresponding dates of fractures to these bones.		
4. Have the osteoporotic fractures directly caused the patient unable to perform (whether aided* or unaided) the following Activities of Daily Living? *Aided shall mean with the aid of special equipment, device and/or apparatus and not pertaining to human aid.	Yes	No

Activity	Please circle if the patient can perform the listed activity?		Period of inability to perform	
			From (dd/mm/yy)	To (dd/mm/yy)
Washing : Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.	Yes	No		
Dressing : Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.	Yes	No		
Transferring : Ability to move from a bed to an upright chair or wheelchair and vice versa.	Yes	No		
Mobility : Ability to move indoors from room to room on level surfaces.	Yes	No		
Toileting : Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain satisfactory level of personal hygiene.	Yes	No		
Feeding : Ability to feed oneself once food has been prepared and made available.	Yes	No		

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

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

SECTION 4 : SEVERE RHEUMATOID ARTHRITIS		
1. Is there evidence of widespread join destruction with major clinical deformity of the joint areas of:		
a. Hands?	Yes	No
b. Wrists?	Yes	No
c. Elbows?	Yes	No
d. Spine?	Yes	No
e. Knee?	Yes	No
f. Ankle?	Yes	No
g. Feet?	Yes	No
If Yes to any of the above, please provide more details to your answer.		
2. Has the patient suffered from any of the following symptoms?		
a. Morning stiffness?	Yes	No
b. Symmetric arthritis?	Yes	No
c. Presence of rheumatoid nodules?	Yes	No
3. Is there evidence of elevated titres of rheumatoid factors?	Yes	No
4. Please state the results of investigations done and attach a copy of the test reports showing elevated titres of rheumatoid factors.		

SECTION 5 : BENIGN TUMOR REQUIRING SURGICAL EXCISION		
1. Was the patient diagnosed to have a non-cancerous benign tumor of any of the following organs:	Yes	No

Please tick the site while the benign tumor occurred :

	Heart		Liver		Lung
	Pancreas		Pericardium		Ureter
	Adrenal gland		Bone		Conjunctiva
	Kidney		Nerve in cranium or spine		Pituitary gland
	Small intestine		Testis		Breasts
	Ovary		Penis		Uterus
	Nasopharyngeal		Esophagus		Oral cavity
	Gallbladder				

2. When was the diagnosis made? _____ (dd/mm/yy)

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

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

3. Please state if the tumor has any of the following characteristics:

☐ Solid ☐ Non-solid (e.g. cyst)

☐ Suspicion of malignancy/ malignant potential ☐ Benign

4. Did the patient underwent surgical excision of the tumor?	Yes	No

5. Was the tumor completely or partially excised?

☐ Partial ☐ Complete

6. Please state the date of surgery. _____ (dd/mm/yy)

7. Please provide a copy of the histological report.

8. Does the patient's condition falls under any of the following:

1. Surgery for ovarian cysts including but not limited to simple cysts, endometrial cysts (endometriomas) of the ovary	Yes	No
2. surgery for removal of tumours in organs not listed above or surgery for removal of gall bladder, gall stones, kidney stones, benign hormone secreting tumours of the adrenal glands	Yes	No
3. surgery for the following causes in all organs		
- High grade dysplasia, lipoma, haemangioma, non-solid tumours including simple cysts	Yes	No
- Tumours which were clearly established as benign or of low malignant potential on radiological criteria or biopsy	Yes	No
- Partial excision of tumour or other procedures including open or closed biopsies, needle aspiration biopsy or cytology, aspiration, embolization or any procedure to reduce tumour size.	Yes	No

SECTION 6 : GLOMERULONEPHRITIS WITH NEPHROTIC SYNDROME

1. Please confirm if the patient has nephrotic syndrome.	Yes	No
a. If Yes, please advise the duration syndrome has persisted with or without intervening periods of remission.	months	

2. Please describe any treatment regimen prescribed to the patient.

a. Please state the period of this treatment regimen.	From (dd/mm/yy)	To (dd/mm/yy)

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

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

b. What is the purpose of this treatment regimen?
c. Has the patient been following this course of treatment or is the patient non-compliant?
3. Please provide the results and attach a copy of investigations done (if any).

SECTION 7 : HAEMOPHILIA A AND HAEMOPHILIA B

1. Please state the type of haemophilia :		
2. Is there a factor VIII or factor IX activity less than 1%?	Yes	No
3. Please provide details on how diagnosis Haemophilia A and Haemophilia B was first made?		
4. Please describe the treatment regimen prescribed to the patient.		

a. Please state the period of this treatment regimen.	From (dd/mm/yy)	To (dd/mm/yy)
b. Has the patient been following this course of treatment or is the patient non-compliant?		
5. Please provide details of all investigations performed. Please attach a copy of the laboratory, X-rays, haematology reports, blood test reports, bone marrow reports, etc.		

SECTION 8 : INSULIN DEPENDENT DIABETES MELLITUS

1. Please provide full and exact details of the diagnosis of Insulin Dependent Diabetes Mellitus.						
2. Was the patient dependent on exogenous insulin?					Yes	No
a. How long has the patient been dependent on exogenous insulin?						months
b. Please provide date of onset of dependence.		DD		MM		YY

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

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

3. What are the types of insulin used by the patient? Please provide brand name.							
4. Please provide details on dosage and frequency and sites of insulin injection.							
5. Please provide details on results of blood or urine testing. If possible, please also give the HbA1c results.							
6. Please provide details with dates of instances where the patient had diabetic coma.							
7. Please provide details of all investigations performed and treatment prescribed. Please also attach a copy of the laboratory investigation results.							
SECTION 9 : KAWASAKI DISEASE WITH HEART COMPLICATIONS							
1. Please provide full and exact details of the diagnosis of Kawasaki with Heart Complications.							
2. Is there evidence of dilation or aneurysm formation in the coronary arteries? If Yes, please advise the following:						Yes	No
a. Please describe results if investigation and attach a copy of the investigation tests performed confirming this.							
b. What is the duration of the coronary artery dilation or aneurysm formation?							months
c. What is the date of onset?		DD		MM			YY
SECTION 10 : OSTEOGENESIS IMPERFECTA							
1. Does the patient have progressive kyphoscoliosis?						Yes	No
2. Please provide full and exact details of the diagnosis of Osteogenesis Imperfecta with the type?							
3. Please provide details on how diagnosis Osteogenesis Imperfecta was first made?							

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

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

4.	Is there a diagnosis confirmed by using a skin punch biopsy?	Yes	No
	a. If Yes, what is the biopsy findings and to attach a copy of the report.	b. If No, please clarify why skin punch biopsy is not required?	
5.	Is the patient suffering with growth retardation and hearing impairment?	Yes	No
	If Yes, please provide details to your answer.		
6.	Is there any multiple fractures of bones present in the X-ray studies?	Yes	No
	If Yes, please provide details to your answer and to state the fracture bones.		
7.	Please describe the treatment regimen prescribed to the patient.		
	c. Please state the period of this treatment regimen.	From (dd/mm/yy)	To (dd/mm/yy)
	d. Has the patient been following this course of treatment or is the patient non-compliant?		
8.	Please provide the results of investigations done including the result of physical examination, result of x-ray and biopsy report.		

SECTION 11 : RHEUMATIC FEVER WITH VALVULAR IMPAIRMENT

1.	Please provide a description of the extent of Rheumatic Fever with Valvular Impairment.		
2.	Please state which of the Jones Criteria for diagnosis of rheumatic fever the patient satisfies.		
3.	Please provide details with supporting evidence of any streptococcal infection.		
4.	Is there any heart valve incompetence?	Yes	No
	a. If Yes, please state valve(s) involved with details including degree of incompetence.		
	b. What is the cause of the heart valve incompetence?		

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

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

c. Is the heart valve incompetence attributable to rheumatic fever?		
d. Please provide results of quantitative investigations on heart valve function.		
5. Please provide details of all investigations performed and treatment prescribed. Please attach a copy of the laboratory investigation results.		

SECTION 12 : STILL'S DISEASE

1. Please advise if there is evidence of the following on the diagnosis of Still's Disease:		
a. Onset of arthritis after 1 month of systemic illness and high fever?	Yes	No
b. High spiking, daily (quotidian) fever?	Yes	No
c. Evanescent rash?	Yes	No
d. Arthritis?	Yes	No
e. Splenomegaly?	Yes	No
f. Lymphadenopathy?	Yes	No
g. Serositis?	Yes	No
h. Weight loss?	Yes	No
If Yes, please state how much weight loss recorded per month.		
i. Neutrophilic leukocytosis?	Yes	No
j. Increase acute phase proteins and sero-negative tests for Antinuclear Antibodies (ANA) and Rheumatoid Factor (RF)?	Yes	No
If Yes to any of the above, please provide more details to your answer.		
2. Please provide details on how diagnosis was first made?		
3. Is there documentation of the condition for at least 6 months?	Yes	No
4. Please provide the results of investigations done including the 6 months' period of documentation.		

SECTION 13 : WILSON'S DISEASE

1. Please provide full and exact details of the diagnosis of Wilson's Disease.						
2. Date of the diagnosis.		DD		MM		YY

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

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

3.	Please provide details on how diagnosis of Wilson's Disease was first made. Please provide the liver biopsy impression in details.						
4.	Is the patient suffering from any neurological symptoms?					Yes	No
	If Yes, please describe in details.						
5.	Please describe the treatment regimen prescribed to the patient.						
6.	Please state the start date of chelating agent prescribed to the patient.		DD		MM		YY
7.	How many months the child is under the chelating agents?						months
8.	Please provide results of the documentary proof supporting your answer in Q7.						
9.	Has the patient been following this course of treatment or is the patient non-compliant?						

SECTION 14 : AUTISM SPECTRUM DISORDER (ASD)

1.	Was the patient diagnosed to have Autism Spectrum Disorder (ASD)?					Yes	No
2.	Was the diagnosis made based on DSM-5 criteria?					Yes	No
3.	Was the diagnosis made by a multi-disciplinary team of developmental paediatrician, child psychologist and clinical psychologist?					Yes	No
4.	When was the diagnosis of ASD made?		DD		MM		YY
5.	Does the patient have any of the following:						
	- marked intellectual disability? please state the IQ level _____					Yes	No
	- significant permanent motor deficits					Yes	No
	- epilepsy disorder					Yes	No

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

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

6. Is the patient on any of the following treatment regime:							
- pharmacological;						Yes	No
- non-pharmacological;						Yes	No
- alternative interventions (e.g. homeopathy, EEG, biofeedback and neurofeedback)						Yes	No
7. Was the treatment recommended by a multidisciplinary team of developmental paediatrician, child psychologist and clinical psychologist?						Yes	No
8. Is the patient enrolled in a qualified specialised centre in Singapore to manage ASD?						Yes	No
9. Was the enrollment at the recommendation of a paediatrician or psychologist?						Yes	No
SECTION 15 : DYSLEXIA							
1. Was the patient diagnosed to have Dyslexia?						Yes	No
2. When was the diagnosis of Dyslexia made?		DD		MM			YY
3. Was the diagnosis of Dyslexia made by an educational psychologist, neurologist or paediatrician?						Yes	No
4. Was the patient enrolled and placed under a recognized Dyslexia literacy program?						Yes	No
SECTION 16 : ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADHD)							
1. Was the patient diagnosed to have Attention-Deficit Hyperactivity Disorder (ADHD)?						Yes	No
2. Was the diagnosis made based on DSM-5 criteria?						Yes	No
3. When was the diagnosis of ADHD made?		DD		MM			YY
4. Was the diagnosis made by a multi-disciplinary team of developmental paediatrician, child psychologist and clinical psychologist?						Yes	No
5. Is the patient on stimulants therapy without interruption for a period of at least six (6) months after diagnosis?						Yes	No
6. Is the patient's ADHD attributable to the physiological effects of a substance or other medical or mental conditions?						Yes	No
SECTION 17 : HAND, FOOT AND MOUTH DISEASE WITH SEVERE COMPLICATIONS							
1. When was the Hand Foot Mouth Disease diagnosed?		DD		MM			YY
2. Please provide full and exact details of the diagnosis of Hand, Foot and Mouth Disease (HFMD).							

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

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

3. Were there symptoms of:		
- Fever	Yes	No
- Poor appetite	Yes	No
- Sore throat	Yes	No
- Headache	Yes	No
- Painful, red blisters in the mouth	Yes	No
- Red rash on the hands and soles of the feet	Yes	No
4. Was the patient admitted to Intensive Care Unit (ICU) for Hand, Foot and Mouth Disease? If yes, please state the period of admission: _____ to _____		
5. Please provide us a copy of the laboratory report showing positive isolation of the causative virus (if any).		
6. Was the Hand, Foot and Mouth Disease associated with any of the following complications? If Yes, please provide details and **attach copies of all** reports, CT Scan, MRI, laboratory test results, etc.		
- Encephalitis	Yes	No
- Myocarditis	Yes	No
7. Was there evidence of permanent neurological deficit lasting for at least 30 days after the date of diagnosis mentioned in Q2 above? Please circle. If Yes, please state the neurological deficits and provide the details.	Yes	No

SECTION 18 : OTHER INFORMATION		
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'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

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

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

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			YY
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 or received treatment for a similar/related illness? 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**
4. Is there anything in the 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 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**
6. Is there anything in the patient's medical history which would have increased the risk of his/her condition?				Yes / No
If Yes, please state the details.				
7. Does the patient have or ever had any other significant health condition? 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**

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.

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