MALE BENEFIT CLAIM FORM

(PRUMAN)

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)

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 tick the appropriate box for the Male Illness / Medical Conditions you are claiming.

Medical Procedure		Medical Procedure		Reconstructive Surgery	
Surgical Septal Myomectomy to relieve the Left Ventricular Outflow Tract (LVOT) obstruction in Hypertrophic Obstructive Cardiomyopathy (HOCM)		Testicular torsion requiring surgery		Facial reconstructive surgery due to an Accident	
Renal Angioplasty		Acquired Peyronie's disease requiring surgery		Skin Grafting due to major burns	
Severe Benign Prostatic Hyperplasia requiring Suprapubic Catheterisation		Orchiechtomy for causes other than cancer		Skin Grafting due to skin cancer	
Support Benefit		Severe Gout		Open surgery for the removal of kidney stones	
Physiotherapy due to an Accident					

4. NATURE OF CLAIM

4.1 Please describe fully the extent and nature of illness / accident.

4.2 Have you previously suffered from or received treatment for a similar or related illness / injury? If yes, please give details.

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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)

☐ 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 bank account
(if you select this payment mode, you need to submit a copy of the bank passbook 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/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 II MEDICAL SPECIALIST REPORT

(To be completed by the life assured's attending medical specialist)

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

SECTION 1

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	
a. 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

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 2

Please complete Question 1 to 7 if patient's condition is on:
Surgical Septal Myomectomy to relieve the Left Ventricular Outflow Tract (LVOT) obstruction in Hypertrophic Obstructive Cardiomyopathy (HOCM)

1. Date of diagnosis of Hypertrophic Obstructive Cardiomyopathy (HOCM).	(DD/MM/YYYY)	
2. What was the underlying cause of patient's Hypertrophic Obstructive Cardiomyopathy (HOCM)?		
3. Was Left Ventricular Outflow Tract Obstruction observed?	Yes	No

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

a. If yes, please provide the magnitude of resting LVOT gradient and copy of the relevant echocardiogram report.

_____ mm Hg at rest

4. Has surgical septal myomectomy been performed to relieve the LVOT obstruction in HOCM by direct removal of cardiac septal muscle?	Yes	No
a. If yes, please state the date surgery was performed.	(DD/MM/YYYY)	
5. Has the patient's diagnosis of Cardiomyopathy resulted in any physical impairment which fulfills the New York Heart Association (NYHA) classification of Cardiac Impairment? a. If YES, please provide the following in detail :	Yes	No

New York Heart Association functional classification	**What is patient's NYHA classification for the current condition? Please tick accordingly.**	**What is the limitation in physical activity patient has?**	**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

6. Did the patient have recurrent syncope related to LVOT obstruction?	Yes	No

a. If yes, please provide details of the syncopal episodes including frequency and length of each episode.

Date: _____ Frequency: _____ Length: _____

Date: _____ Frequency: _____ Length: _____

Date: _____ Frequency: _____ Length: _____

Date: _____ Frequency: _____ Length: _____

Date: _____ Frequency: _____ Length: _____

(Please continue your documentation on a separate piece of paper if there is insufficient space)

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

7. Was there any other method of treatment, other than surgical septal myomectomy, which could have been used to treat the patient's Hypertrophic Cardiomyopathy? a. Please specify the name of the alternative method of treatment.		
b. Date the alternative method of treatment was/ will be performed.	(DD/MM/YYYY)	
Please complete Question 8 to 15 if patient's condition is on: **Renal Angioplasty**		
8. Please indicate the type of procedure that was performed.		
9. Please state the date the procedure was performed.	(DD/MM/YYYY)	
10. Please specify the percentage of stenosis in the left and/or right renal arteries. Please also provide the relevant angiographic and imaging reports.	Left	Right
11. Please confirm if the procedure performed was medically necessary.	Yes	No
12. Has the patient undergone a similar procedure before?	Yes	No
a. If yes, please state place where this procedure was performed.		
b. Please state the date the procedure was performed.	(DD/MM/YYYY)	
13. Was the surgery performed for investigation or diagnostic purpose?	Yes	No
14. Has the patient previously suffered from raised cholesterol, hypertension, diabetes or any other disorder of the blood vessels?	Yes	No
15. Is there anything in patient's medical history which would increase the risk of having renal artery stenosis?	Yes	No
a. If yes, please state what it is?		

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

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

Please complete Question 16 to 21 if patient's condition is on: Severe Benign Prostatic Hyperplasia requiring Suprapubic Catheterisation		
16. When was the condition for acute urinary retention observed?	(DD/MM/YYYY)	
17. Was the condition for acute urinary retention related to severe benign prostatic hyperplasia?	Yes	No
18. Please state the date of procedure that was performed? Please provide surgery report.	(DD/MM/YYYY)	
19. What was the reason for urethral catheterisation and suprapubic catheterization?		
20. Please confirm if the procedure performed was medically necessary.	Yes	No
21. Has the patient undergone a similar procedure before?	Yes	No
a. If yes, please state date of procedure and provide copy of report.	(DD/MM/YYYY)	
Please complete Question 22 to 27 if patient's condition is on: Testicular torsion requiring surgery		
22. Please indicate the type of surgery that was performed. Please provide us with a copy of the operation report.		
23. Please state the date the procedure was performed.	(DD/MM/YYYY)	
24. Is the testicular torsion associated with any underlying causes or conditions?		
25. If the testicular torsion was caused by an accident, please provide the following information: i) Date of accident : (dd/mm/yyyy) ii) Place of the accident : iii) Nature of accident :		
26. Please confirm if the procedure performed was medically necessary.	Yes	No

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

27. Was the surgery performed for investigation or diagnostic purpose?	Yes	No
Please complete Question 28 to 31 if patient's condition is on: Acquired Peyronie's disease requiring surgery		
28. Was penile surgery done to correct non-congenital penis curvature?		
29. Please state the date the procedure was performed.	(DD/MM/YYYY)	
30. Was there any other non-surgical treatments performed? (including but not only confining to penile traction, penile intralesional injection).	Yes	No
a. If yes, please indicate the type of treatment that was performed.		
b. Please state the date the first treatment was administered.	(DD/MM/YYYY)	
31. Please confirm if the procedure performed was medically necessary.	Yes	No
Please complete Question 32 to 36 if patient's condition is on: Orchiectomy for causes other than cancer		
32. What type of orchiectomy surgery was performed - simple, subcapsular, or inguinal?		
33. What is the underlying cause or condition for orchiectomy?		
34. Is the underlying cause or condition for orchiectomy related to cancer?	Yes	No
a. If yes, please provide details : i) date of diagnosis : (DD/MM/YYYY) ii) practicing address of the treating doctor :		

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

35. Please confirm that the procedure was medically necessary.	Yes	No
36. Was orchiectomy performed due to sex reassignment or male sterilization?	Yes	No
Please complete Question 37 to 42 if patient's condition is on: Severe Gout		
37. Has patient undergone x-ray examination? a. If yes, please state date of x-ray performed: (DD/MM/YYYY)	Yes	No
38. Did the x-ray test results show abnormality of bone and /or joint deformities?	Yes	No
a. If yes, please state the site of the bone abnormality and /or joint deformities.		
39. Was there intracellular needle shaped crystals in fluid drawn from the affected joint?	Yes	No
a. If joint fluid test was not performed, please state the reason of joint fluid test was not performed :		
40. Has the patient undergone blood test to measure the levels of uric acid?	Yes	No
a. If yes, please provide details and copy of test report: i) date of test performed : (DD/MM/YYYY) ii) Measurements (mg/dL) of serum uric acid :		
41. Did the patient undergone any other tests to support the diagnosis of gout?	Yes	No
a. If yes, please provide details of the tests done and copy of test report: i) date of test performed : (DD/MM/YYYY) ii) Name of test : iii) Results :		
42. Was there ongoing medical treatment for at least 6 months due to gout? Please provide proof of treatments administered.	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 43 to 51 if patient's condition is on: **Facial reconstructive surgery due to an Accident;** **Skin grafting due to Major burns**		
43. Date of accident: (DD/MM/YYYY)	Place of accident:	
44. Please describe how the accident happened.		
45. Please describe the nature and extend of injuries sustained.		
46. Was the accident reported to the police? Please provide copy of police report.	Yes	No
a. If yes, please provide the name of the police officer and police station at which the accident was reported and a copy of the police report.		
47. Which areas of the body were affected by burns?		
48. What percentage of the body surface was affected by 3rd degree burns?	%	
49. Did the patient undergo any skin grafting?	Yes	No
50. Please state the date of the surgery and provide a copy of the operation report.	(DD/MM/YYYY)	
51. Did the patient undergo any facial reconstruction due to the accident?	Yes	No
a. If yes, please state the date of the surgery _____ (DD/MM/YYYY); and b. nature of reconstruction performed Please also provide a copy of the operation report.		

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

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

Please complete Questions 52 to 59 if patient's condition is on: Skin Grafting due to skin cancer		
52. Please state the origin of the malignant tumor.		
53. What is the staging of the tumor? Please indicate the TNM staging or its equivalent.		
54. Were regional lymph nodes involved?	Yes	No
55. Is this an invasive cancer based on the histology report? (Please attach a copy of the histology report)	Yes	No
56. Is the patient's condition squamous cell skin cancer?	Yes	No
57. Is the patient's condition invasive melanoma of less than 1.5mm Breslow thickness, or less than Clark Level 3?	Yes	No
58. Has the tumor been surgically excised?	Yes	No
a. Please state the nature of the surgery performed and date of the surgery (please attach a copy of the operation report).		
59. Did the patient undergo any reconstructive surgery or skin grafting due to cancer?	Yes	No
a. If yes, please state the nature of the operation and when it was performed (please attach a copy of the operation report).		

Please complete Questions 60 to 64 if patient's condition is on: Open surgery for the removal of kidney stones		
60. Please state the date kidney stones were discovered.	(DD/MM/YYYY)	
61. Was open surgery performed to remove kidney stones?	Yes	No
62. Please state the date that open surgery was performed.	(DD/MM/YYYY)	

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

63. Please state the type of surgery performed (i.e. open surgery, extracorporeal shock wave lithotripsy (ESWL), ureteroscopy, percutaneous nephrolithotomy (PCNL), key-hole surgery, etc.)		
64. Was there any other non-surgical treatments performed? (including but not only confining to Extracorporeal shock wave lithotripsy (ESWL), ureteroscopy, percutaneous nephrolithotomy (PCNL) or any other form of keyhole surgery?	Yes	No
a. If yes, please provide details and copy of test report: i) date of test performed : (DD/MM/YYYY) ii) Name of procedure :		
Please complete Question 65 to 73 if the patient's condition is on: Physiotherapy due to an Accident		
65. Date of accident: (DD/MM/YYYY)	Place of accident:	
66. Please describe how the accident happened.		
67. Describe full the extent and nature of illness / injuries sustained.		
68. Was the accident reported to the police?	Yes	No
a. If yes, please provide the name of the police officer and police station at which the accident was reported and a copy of the police report.		
69. Please describe the symptoms that have necessitated the physiotherapy.		
70. Is the physiotherapy treatment associated with any underlying causes or conditions?		
71. Was the physiotherapy recommended by the treating medical doctor? Please provide memo of recommendation by treating medical doctor.	Yes	No

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

72. Was there physiotherapy treatment of physical functions loss or impairment as a result of an Accident?	Yes	No
a. If yes, please state the details of the extent of physical function loss of impairment.		
73. Please provide name and practice address of the physiotherapist administering the physiotherapy.		

SECTION 3		
1. Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?	Yes	No
If yes, please provide the date of diagnosis of HIV/ AIDS.	(DD/MM/YYYY)	
2. Is the diagnosis related to a deliberate act of taking intoxicating liquor, drugs or poison, suicide or attempted suicide or intentional self-injury?	Yes	No
a. 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
a. If yes, please provide details.		

SECTION 4		
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

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

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

1. Is the patient suffering from any significant medical condition? If yes, please provide the following information:	Yes	No
a) Diagnosis : : b) Date of diagnosis (dd/mm/yyyy) : c) 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

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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