PRUDENTIAL

PruCustomer Line: 1800 -333 0 3333

CRISIS COVER CLAIM FORM

ADDITIONAL CRITICAL ILLNESS & MEDICAL CONDITION

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

☐ Acute Necrohaemorrhagic pancreatitis	☐ Infective endocarditis	☐ Progressive supranuclear palsy
☐ Adrenalectomy for adrenal adenoma	☐ Medullary cystic disease	☐ Severe Crohn's disease
☐ Creutzfeld-Jacob disease	☐ Meningeal tuberculosis	☐ Severe Eisenmenger's syndrome
☐ Chronic auto-immune hepatitis	☐ Multiple root avulsions of brachial plexus	☐ Surgery for idiopathic scoliosis
☐ Ebola	☐ Necrotising fasciitis	☐ Severe ulcerative colitis
☐ Elephantiasis	☐ Pheochromocytoma	☐ Severe myasthenia gravis
☐ Idiopathic pulmonary fibrosis		

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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		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
ADDITIONAL CRITICAL ILLNESS & MEDICAL CONDITION
(To be completed by the Life Assured's attending medical specialist)

Please circle the appropriate illness/disease/condition in the table and complete the relevant sections in respect to the illness/disease/condition claims. **Please submit ONLY the relevant sections to us upon completion.**

	Critical Illness	Sections to be completed
1	Acute Necrohaemorrhagic pancreatitis	1, 2, 21, 22
2	Adrenalectomy for adrenal adenoma	1, 3, 21, 22
3	Creutzfeld-Jacob disease	1, 4, 21, 22
4	Chronic auto-immune hepatitis	1, 5, 21, 22
5	Ebola	1, 6, 21, 22
6	Elephantiasis	1, 7, 21, 22
7	Idiopathic pulmonary fibrosis	1, 8, 21, 22
8	Infective endocarditis	1, 9, 21, 22
9	Medullary cystic disease	1, 10, 21, 22
10	Meningeal tuberculosis	1, 11, 21, 22
11	Multiple root avulsions of brachial plexus	1, 12, 21, 22
12	Necrotising fasciitis	1, 13, 21, 22
13	Pheochromocytoma	1, 14, 21, 22
14	Progressive supranuclear palsy	1, 15, 21, 22
15	Severe Crohn's disease	1, 16, 21, 22
16	Severe Eisenmenger's syndrome	1, 17, 21, 22
17	Surgery for idiopathic scoliosis	1, 18, 21, 22
18	Severe ulcerative colitis	1, 19, 21, 22
19	Severe myasthenia gravis	1, 20, 21, 22

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

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

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:						
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?		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.						

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

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

SECTION 2 : ACUTE NECROHAEMORRHAGIC PANCREATITIS		
1. Did the patient undergo any surgical clearance of necrotic tissue or pancreatectomy?	Yes	No
2. If yes, please state the nature of the surgery performed. Please also provide a copy of the operation report.		
3. Date the surgery was performed	(dd/mm/yy)	
4. Was the diagnosis of Acute Necrohaemorrhagic pancreatitis confirmed on histological evidence?	Yes	No
Please provide a copy of the histology report.		
5. Was the cause of the pancreatitis due to alcohol or drug abuse?	Yes	No
If yes, please provide details.		

SECTION 3 : ADRENALECTOMY FOR ADRENAL ADENOMA		
1. Was the adrenalectomy performed for treatment of malignant systemic hypertension?	Yes	No
2. Was the malignant systemic hypertension secondary to an aldosterone secreting adrenal adenoma?	Yes	No
3. Was the malignant hypertension able to be controlled by medical therapy?	Yes	No
4. If yes, please state the medical therapy prescribed.		

SECTION 4 : CREUTZFELD-JACOB DISEASE		
1. Has the patient's condition resulted in an associated neurological deficit?	Yes	No
2. Please describe the neurological deficit.		
3. Is the neurological deficit permanent?	Yes	No

4. Please advise if the deficit has resulted in the patient's inability to perform the Activities of Daily Living.

ADLs	Is the patient able to perform the ADL independently?	When did the patient became unable to perform such ADLs?	Is the inability to perform the ADL permanent?
Washing			
Dressing			
Transferring			
Mobility			
Toileting			
Feeding			

5. Was the disease caused by human growth hormone treatment?	Yes	No
Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date	

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

SECTION 5 : CHRONIC AUTO-IMMUNE HEPATITIS		
1. Is there presence of hypergammaglobulinaemia?	Yes	No
2. Is there presence of any of the following auto-antibodies?		
- Anti-nuclear antibody (ANA)	Yes	No
- Anti-smooth muscle antibodies	Yes	No
- Anti-actin antibodies	Yes	No
- Antibodies to Liver-Kidney Microsome (Anti-LKM-1)	Yes	No
- Anti- LC1 antibodies	Yes	No
- Anti-SLA/ LP antibodies	Yes	No
3. Please advise if a liver biopsy was performed	Yes	No
If yes, please provide us with a copy of the liver biopsy results confirming the diagnosis of Chronic auto-immune hepatitis.		
SECTION 6 : EBOLA		
1. Was the patient infected with the Ebola virus?	Yes	No
2. Was the presence of the virus confirmed by laboratory testing?	Yes	No
Please provide us with a copy if the laboratory test results confirming the presence of the Ebola virus		
3. Were there evidence of ongoing complications of the infection persisting more than 30 days from the onset of the symptoms?	Yes	No
4. Did the infection resulted in death of the patient	Yes	No
5. Was there any effective cure for the virus	Yes	No
SECTION 7 : ELEPHANTIASIS		
1. Was there an unequivocal diagnosis of Elephantiasis?	Yes	No
2. Was the diagnosis supported by laboratory confirmation of microfilariae	Yes	No
3. Was there lymphedema caused any of the following:		
- infection with other disease(s)	Yes	No
- trauma, post-operative scarring	Yes	No
- congestive heart failure	Yes	No
- congenital lymphatic system abnormalities	Yes	No
SECTION 8 : IDIOPATHIC PULMONARY FIBROSIS		
1. Does the patient require extensive and permanent oxygen therapy?	Yes	No
2. If yes, how many hours of oxygen therapy does he require per day _____ (no. of hours)		
3. Is the patient's lung function consistently showing: - FVC $\leqslant$ 50%? - DLCO $\leqslant$ 35% of predicted value?	Yes Yes	No No
Please provide a copy of the patient's lung function results.		
4. Was the diagnosis of idiopathic pulmonary fibrosis confirmed on lung biopsy? Please provide us with a copy of the biopsy results.		
Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date	

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

SECTION 9 : INFECTIVE ENDOCARDITIS		
1. Was the patient's endocarditis caused by infective organisms?	Yes	No
2. Are there presence of any or all of the following:		
- positive result of the blood culture proving presence of the infectious organism?	Yes	No
- presence of at least moderate heart valve incompetence (meaning regurgitant fraction of 20% or above) or moderate heart valve stenosis (resulting in heart valve area of 30% or less of normal value) attributable to infective endocarditis?	Yes	No
3. Was the diagnosis of infective endocarditis and the severity of valvular impairment confirmed by a cardiologist?	Yes	No
SECTION 10 : MEDULLARY CYSTIC DISEASE		
1. Was there presence of multiple cysts in the renal medulla?	Yes	No
2. Was it accompanied by the presence of tubular atrophy and interstitial fibrosis?	Yes	No
3. Were there clinical manifestations of the following:		
- anaemia	Yes	No
- polyuria	Yes	No
- progressive deterioration in kidney function	Yes	No
4. Was the diagnosis of Medullary cystic function confirmed by renal biopsy?	Yes	No
Please provide us with a copy of the renal biopsy results.		
5. Does the patient have isolated or benign kidney cysts?	Yes	No
SECTION 11 : MENINGEAL TUBERCULOSIS		
1. Does the patient have meningitis caused by tubercle bacilli?	Yes	No
2. Did the condition result in permanent* neurological deficit?	Yes	No
If yes, please specify the neurological deficits suffered by the patient.		
3. Was the evidence of permanent* clinical neurological deficit confirmed at least 6 weeks after the diagnosis of Meningeal tuberculosis?	Yes	No
4. Were there findings of M. tuberculosis infection confirmed on cerebrospinal fluid by lumbar puncture and CSF culture?	Yes	No
**expected to last throughout the lifetime of the patient*		
SECTION 12 : MULTIPLE ROOT AVULSIONS OF BRACHIAL PLEXUS		
1. Does the patient suffer from complete and the permanent loss of use and sensory functions of an upper extremity	Yes	No
2. Was it caused by avulsion of 2 or more nerve roots of the brachia plexus?	Yes	No
3. Was the loss sustained through an accident or injury?	Yes	No
Please provide details of the accident or injury.		
4. Was the injury to the nerve roots confirmed by electrodiagnostic study	Yes	No

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

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

SECTION 13 : NECROTISING FASCIITIS		
1. Were the usual clinical criteria for necrotizing fasciitis met?	Yes	No
2. Was the bacterial identified a known cause of necrotizing fasciitis?	Yes	No
3. Were there widespread destruction of muscle and other soft tissues?	Yes	No
4. Did the widespread destruction result in a total and permanent loss of function in the affected body part?	Yes	No
Please specify the loss of function and the affected body part.		
SECTION 14 : PHEOCHROMOCYTOMA		
1. Was the patient diagnosed to have Pheochromocytoma?	Yes	No
2. Did the patient undergo a surgical removal of the tumor?	Yes	No
3. Was the diagnosis of Pheochromocytoma made upon a histopathological examination?	Yes	No
Please provide us with a copy of the histology report confirming the diagnosis.		
SECTION 15 : PROGRESSIVE SUPRANUCLEAR PALSY		
1. Was the occurrence of Progressive supranuclear palsy independent of all other causes?	Yes	No
2. Did it result in permanent neurological deficit?	Yes	No
If yes, please specify the neurological deficits suffered by the patient.		

3. Please advise if the deficit has resulted in the patient's inability to perform the Activities of Daily Living.

ADLs	Is the patient able to perform the ADL independently?	When did the patient became unable to perform such ADLs?	Is the inability to perform the ADL permanent?
Washing			
Dressing			
Transferring			
Mobility			
Toileting			
Feeding			

SECTION 16 : SEVERE CROHN'S DISEASE		
1. Is there evidence of continued inflammation in spite of optimal therapy?	Yes	No
2. Is the patient's condition evidenced by any or all of the following:		
- Stricture formation causing intestinal obstruction requiring admission to hospital	Yes	No
- Fistula formation between loops of bowel	Yes	No
- At least one (1) bowel segment resection	Yes	No
3. Was the diagnosis of Crohn's disease confirmed on histological findings Please provide us with a copy of the histology report.	Yes	No
Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date	

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

SECTION 17 : SEVERE EISENMENGER'S SYNDROME			
1.	Was the reversed or bidirectional shunt caused by a result of pulmonary hypertension caused by a heart disorder?	Yes	No
2.	Was the patient symptomatic during ordinary daily activities despite the use of medication and dietary adjustment?	Yes	No
3.	Was there evidence of abnormal ventricular function on physical examination and laboratory studies?	Yes	No
	Please provide us with a copy of the laboratory results.		
4.	Was there presence of permanent physical impairment classified as NYHA Class IV?	Yes	No

Please provide details of the NYHA classification 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

SECTION 18 : SURGERY FOR IDIOPATHIC SCOLIOSIS			
1.	Is the patient suffering from scoliosis?	Yes	No
2.	Was the curve of the spine more than cobb angle 40 degree?	Yes	No
3.	Was there an identifiable underlying cause for the scoliosis?	Yes	No
	If yes, please state the underlying cause.		
4.	Was the spinal deformity associated with any congenital defects and neuromuscular diseases?	Yes	No
	If yes, please provide details of the congenital defect and neuromuscular diseases.		
5.	Has the patient undergone any spinal surgery to correct the abnormal curvature of the spine from its normal straight line viewed from the back?	Yes	No

If yes, please state the date of surgery and the nature of surgery performed.

Date of surgery: _____ (DD/ MM/ YYYY)

Nature of surgery: _____

SECTION 19 : SEVERE ULCERATIVE COLITIS			
1.	Was the patient diagnosed to have ulcerative colitis?	Yes	No
2.	Did his/ her condition present with any of the following criteria:		
	- The entire colon is affected with severe bloody diarrhea;	Yes	No
	- He/ She was treated with total colectomy and ileostomy;	Yes	No
	- The diagnosis was confirmed on histological features and confirmed by a gastroenterologist	Yes	No

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

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

SECTION 20 : SEVERE MYASTHENIA GRAVIS		
1. Is the patient suffering from myasthenia gravis?	Yes	No
2. Did his/ her condition present with permanent muscle weakness categorized as Class III, IV or V according to the Myasthenia Gravis Foundation of America Clinical Classification?	Yes	No

Myasthenia Gravis Foundation of America Clinical Classification:
Class I - Any eye muscle weakness, possible ptosis, no other evidence of muscle weakness elsewhere
Class II - Eye muscle weakness of any severity, mild weakness of other muscles
Class III - Eye muscle weakness of any severity, moderate weakness of other muscles
Class IV - Eye muscle weakness of any severity, severe weakness of other muscles
Class V - Intubation needed to maintain airway

3. Was the diagnosis confirmed by a neurologist?	Yes	No

SECTION 21 : 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 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 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 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

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

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 Part II	Date
Practice Stamp of the Medical Specialist	

SECTION 22
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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