PRUDENTIAL

GROUP TPD CLAIM FORM

This form is to be completed by the Claimant.
The Company does not admit liability by the mere issue of this form.

POLICYHOLDER AND LIFE ASSURED

Name of Policyholder : ______ Policy No. : ______

Name of Life Assured : ______ NRIC/PP No. : ______

Cover Start Date : ___ ___ ___ (*DD* *MM* *YYYY*) Date of Birth : ___ ___ ___ (*DD* *MM* *YYYY*)

Sum Assured : ______ Sex : *F* / *M*

Marital Status : *Single* / *Married*

Name and Signature of Authorised Representative ______ Company's Stamp ______ Date ______

Contact No. : ______

DETAILS OF OCCUPATION

	Before disability	**After disability**
Occupation		
Name of Employer		
Average monthly income		
List exact duties performed at work [see note (i)]		

Note: i) If you are not working, please provide a list of daily activities before and after the disability
ii) The Company reserves the right to request for documentary evidence

DETAILS OF DISABILITY

Is the disability suffered due to: ☐ Illness ☐ Accident

Date symptoms started: ______

Date & time of accident: ______

Describe in detail all symptoms and/or nature of injuries/disability suffered: ______

Are you currently confined to: ☐ Bed ☐ House ☐ Neither

Date you last worked: ______

Date you returned / expect to return to work: ______

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Details of physician(s) consulted or hospital(s) admitted for this disability.

Name(s)	Address(es)	Admission Dates

Details of your regular physician or any other physician(s) consulted for any other disorders in the past three years.

Name(s)	Address(es)	Reason for Consultation

Other Claims

Are you claiming from any other insurance company or other sources in respect of this disability?
If yes, please provide following information.

Name of Company	Amount Claimed	Policy No. (if applicable)

DECLARATION

I hereby declare that the statements and answers given above are true and complete to the best of my knowledge and belief and that I have not made any false or fraudulent statement, any suppression and concealment of facts. I consent to the Prudential Assurance Co. Singapore (Pte) Ltd seeking medical information from any doctor who, at any time, has attended to me concerning anything which affects my physical or mental health or seeking information from any insurance office to which a proposal has been made for insurance on my life and I authorize the giving of such information. A photographic copy of this authorization shall be as valid as the original.

Signature of Claimant ______________________ Date ____________

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Part of Prudential Corporation plc

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Attending Physician's Statement

(To be completed by attending physician at insured's expense)

Name of Patient

NRIC No.

Please complete this form as fully as possible. Your kind assistance will help to expedite our assessment of the claim.

1. Consultation for present illness/injury
   (a) Are you the patient's usual physician? Yes / No — If yes, since what date?
   (b) When did the patient first consult you for this illness or injury?
   (c) If consultation was for illness, please provide the following information:
      (i) symptoms presented
      (ii) duration of these symptoms
      (iii) diagnosis
      (iv) was the diagnosis made known to the patient? Yes / No — If yes, when? If no, why?
   (d) If consultation was for injury please describe injuries:

2. Patient's condition
   (a) Please describe the nature and severity of the patient's disability.
   (b) To what extent does his disability prevent him from performing all the normal duties of his usual occupation?
   (c) If he cannot return to his usual occupation, can he engage in any other type of occupation?

3. Please describe treatment, including any operations performed.

4. Has the patient been referred from a clinic or hospital? Yes / No — If Yes, please state:
   (a) Name of physician
   (b) Name of clinic/hospital
   (c) Date referred

5. Has the patient been admitted to hospital before for the same illness/injury — Yes / No — If yes, please state:
   (a) Date admitted
   (b) Date discharge
   (c) Name of hospital
   (d) Admission No.

6. (a) Has the patient suffered or is suffering from any other disease or ailment? — Yes / No — If yes, please give details
   (b) Date he first suffered from the disease or ailment
   (c) Name and address of physician consulted

7. **In your opinion, is the patient**
   (a) **total and permanently disabled AND**
   (b) **cannot engage in <u>any</u> occupation, business or activity which pays an income.**

8. (a) Is the patient suffering from **total and irrecoverable loss of use of the right eye and the left eye** — Yes / No — If yes, please give details

(b) Is the patient suffering **from total and irrecoverable loss of use of any two limbs at or above the wrist or ankle**

Yes | No | If yes, please give details

(c) Is the patient suffering from **total and irrecoverable loss of use of one eye and any one limb at or above the wrist or ankle**

Yes | No | If yes, please give details

9. (a) Is the patient **dependent on other caregiver** for his everyday living activities, e.g. changing, transferring from place to place, eating, bathing, managing his finances etc.

Yes | No | If yes, please specify and give details

(b) In your opinion, will he require such assistance **permanently**?

Yes | No | please comment on your opinion

10 (a) How would you assess the patient's degree of limitation in performing the following activities? (Please tick)

	Not Limited	Mildly Limited	Moderately Limited	Severely Limited	Incapable
Seeing / Vision					
Hearing / Sound					
Reasoning / Mental Faculty					
Speech					
Standing					
Sitting					
Walking					
Changing Posture					
Bending					
Driving					
Squatting					
Kneeling					
Climbing Stairs					
Working with both hands					
Lifting & Carrying					
Eating					
Bathing					
Dressing					
Using the lavatory					
Reach above the shoulders					
Walk on uneven surface					
Inability to move in / out of chair					

10 (b) To what extent can the patient use his/her hand?

	Right Hand	Left Hand
Simple Grasping		
Fine Manipulation		
Forearm rotation movement		
Power Grip		
Pushing / Pulling		

10 (c) What is the grading of muscle strength for:

Right Leg

Left Leg

11) Please provide us with any other additional information that will enable the company to assess this claim.

Date

Signature of Physician

Hospital/Clinic Stamp

Name

Designation

Qualifications