PRUDENTIAL

Reg. No 199002477Z

CLINICAL ABSTRACT APPLICATION FORM MD 105	Instructions 1 This form must be fully completed for the application of a medical report. It should be signed by the patient or the patient's parent (if patient is below 21 years of age) or the patient's next – of –kin (if patient is deceased), and be duly witnessed. 2 This form is to be submitted with the appropriate report fee. 3 The release of the medical report is subject to official approval.

Dear Sir / Doctor

I, ____ NRIC NO. ____________________

of ____
(Address of patient)

hereby authorize you to furnish Prudential Assurance Company Singapore (Pte) Limited with a medical report on

____ NRIC No. _________________________
(Name of patient)

who was treated at the hospital /Clinic. Besides the medical report fee, I undertake to pay any additional charges such as X-ray and laboratory investigation charges which may be incurred in the preparation of the medical report.

I agree and confirm that a photocopy of this executed Clinical Abstract Application form is as valid and effective as the original Clinical Abstract Application form; and

The medical report is required 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**").

Name (in block letters): ______________________________

____________________________________ Relation to patient : ___________________________
Signature of Patient / Parent / Next-of-Kin

Duly Witnessed By:

____________________________________ Name (in block letters): ______________________________
Signature

NRIC NO. : ___________________________ Address : ______________________________________