PruHospital Income Claim Form

(To be completed by Claimant)

1. The Company does not admit liability by the mere issuance of this form.

2. Please complete and return this form together with the Medical Report and the original Medical Certificate, Original bills and receipt to the Company.

Important Note: 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.

Personal Particulars

Name of Claimant	NRIC Number	Policy Number

Address	Contact Number

PAYMENT METHOD FOR CLAIM SETTLEMENT

PayNow (Default Payment Method)
Any amount payable (if any) can only be made to the Policy Owner and will be paid via transfer to your **PayNow NRIC/FIN ID** by default. Please ensure that you have signed up for PayNow with your bank by linking it to your **NRIC/FIN**. Terms and conditions apply (https://www.prudential.com.sg/PN-tnc).

To register for PayNow
Log in to your bank's internet or mobile banking account > Sign up for PayNow > Link your PayNow to your NRIC/FIN

Cheque will be issued for Policy Owners who do not have a valid Singapore NRIC/FIN or have opted out of PayNow as default in PRUaccess.

Direct Credit (Application Required)
If you do not wish to receive payment via PayNow (NRIC/FIN), you may choose to receive payments via direct transfer to the Policy Owner's bank account.

Please fill in your bank details below and **submit** a copy of the policyowner's bank book or bank statement, stating the account holder's name and account number. We accept bank statements with the bank balances and transactions being blacked out, and truncated e-statements downloaded from the banks' mobile application, provided that the document shows the account holder's name and account number on the same page.

Name of Account Holder	Name of Bank	Bank Account Number

Details of Claim

Benefit Plan Type

☐ Plan 1 ☐ Plan 2 ☐ Plan 3

Type of Claim

☐ Daily Hospital Income

☐ Daily Hospital Overseas Income

☐ Daily Intensive Care Unit Benefit

☐ Compassionate Boarding Fee

☐ Hospital Expenses (Illness) Reimbursement

☐ Hospital Expenses (Accident) Reimbursement

☐ Discharge Transportation Grant

☐ Recuperation Grant

☐ Temporary Disablement Benefit

☐ Death

☐ 24-Hour Worldwide Accidental Emergency Assistance Service

Details of Illness / Injury

1. What is the cause of illness / injury

☐ Illness Date symptoms first started ☐

☐ Accident Date and Time of Accident ☐

2. Was there a police report Yes ☐ No ☐
(If Yes, please provide a copy.)

3. Describe in detail the nature of the illness / injury. If the condition is caused by an accident, please give details on the accident.

Please go to the benefits that you are claiming for and fill in accordingly

1. Daily Hospital Income Benefit

Date of hospitalization: From _____ to _____

Have you suffered this or a similar condition or a recurrence of a previous illness or injury

☐ Yes ☐ No If Yes, please specify _____

Date of first consultation of the injury/illness _____

Date in which you first noticed symptoms of condition _____

2. Daily Hospital Overseas Income (Applicable to hospital in the USA, Canada, Switzerland, Japan or member of the European Union)

Country visited _____ Duration of visit _____

Purpose_____

State the country of hospital _____

Date of hospitalization: From _____ to _____

3. Daily Intensive Care Unit Benefit

Number of ICU stays: _____

4. Compassionate Boarding Fee

Names of Boarders _____ relationship _____

Date of boarding: From _____ to _____

5. Hospital Expenses (Illness) Reimbursement

Medical Expenses _____

Are you claiming Medical Expenses from other sources Yes ☐ No ☐

If yes, please provide details of claim:

Name of Company	Nature of Claim	Amount Claimed	Policy Number (if applicable)

6. Hospital Expenses (Accident) Reimbursement

Medical Expenses _____

Are you claiming Medical Expenses from other sources? Yes ☐ No ☐

If yes, please provide details of claim:

Name of Company	Nature of Claim	Amount Claimed	Policy Number (if applicable)

7. Discharge Transportation Grant ☐

8. Recuperation Grant ☐

9. Temporary Disablement Benefit

Date of medical certificates : From _____ to _____

10. Death

Date of Death : _____

Cause of Death : _____

Name of Claimants : _____

Name of Life Assured:	NRIC / Passport No. of Life Assured:

DECLARATION

1. 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 agree that if I have provided any false or fraudulent information, or suppress, conceal and/or falsely state any material facts with regard to this claim, the policy shall be void and all rights of recovery in respect of past or future claims shall be forfeited.

2. I 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 understand and agree that the submission of this form does not mean that my request will be processed, and that any payout under the policy shall be in PACS sole and absolute discretion. I further acknowledge and agree that the furnishing this form or other supplemental formsby 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 or derfences.

4. I hereby warrant and represent that I have been duly authorised to submit this claim and all information submitted in connection with the claim and policy.

5. I acknowledge and accept that PACS expressly reserves its rights to require or obtain further information and documentation as it deems necessary. I acknowledge that I am solely responsible for the costs of providing such information and documentation as requested by PACS.

6. I confirmed 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 form other company(ies)/person(s).

7. I agree to produce all original document(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 arising under this form and such other purposes ancillary or related to the assessing, processing and investigating my claim(s), (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 the 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. 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.

10. 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.

11. I agree to receive communication on the claim by email, SMS and/or hard copies by post.

12. 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 & Signature of Life Assured above age 18 years

Date & Signature of Policyowner

Relationship to Life Assured