CLAIM FORM

Please complete in DARK BLACK ink only and TICK (√) the boxes where appropriate.

Policy Number

1. 2. 3.

4. 5. 6.

Date Submitted (dd/mm/yy)

Agent's Code/Bank/Prudential Assurance Malaysia Berhad Representative's Number

Agent/Bank/Prudential Assurance Malaysia Berhad Representative's Name

Agent/Bank/Prudential Assurance Malaysia Berhad Representative's Contact Number

Note: Correspondences in relation to this claim will be delivered to the agent / bank representative / Prudential representative stated above, unless claimant explicitly specifies his / her preferred method.

Correspondence Delivery Method: ☐ Send directly to Claimant ☐ Collection at PAMB / Bank Branches:

PART 1: TYPE OF CLAIM

Medical [68]

Hospitalisation / Day Care Surgery

- ☐ Hospitalisation / Day Care Surgery
- ☐ Overseas Treatment
- ☐ Partially Settled By Other Insurers
- ☐ Surgical & Nursing Loan

Outpatient Treatment

- ☐ Pre & Post Hospitalization
- ☐ Emergency Treatment of Accidental Injury
- ☐ Outpatient Cancer & Kidney Dialysis / Dengue Fever Treatment
- ☐ Home Nursing Care

Allowance Benefits

- ☐ Hopitalization Benefit / Allowance
- ☐ Well Being Benefit

Deductible Accumulation

- ☐ Deductible Accumulation

Personal Accident *Kemalangan Peribadi* [67]

- ☐ Accident Medical Reimbursement
- ☐ Weekly Indemnity
- ☐ Accidental Disablement

Critical Illness

[11]

- ☐ Crisis Cover

[69]

- ☐ Crisis Cover Income

Total and Permanent Disability [12]

- ☐ Total and Permanent Disability
- ☐ Total and Permanent Disability Instalment Benefit
- ☐ Long Term Care Benefit

Death *Kematian* [09]

- ☐ Death

Others *Lain-lain*

[11]

- ☐ Essential Child Benefit

[57]

- ☐ Neonatal Jaundice
- ☐ Life Stage / Life Change Benefit
- ☐ Incubation / Intensive Care Unit / High Dependency Unit
- ☐ Snatch Theft Benefit
- ☐ Congenital Conditions
- ☐ Female Carcinoma-in-situ / Recovery Benefit
- ☐ Pregnancy / Maternity Complication
- ☐ Infectious Disease Benefit
- ☐

Prudential Assurance Malaysia Berhad (107655-U)
Level 20, Menara Prudential, Persiaran TRX Barat, 55188 Tun Razak Exchange, Kuala Lumpur, Malaysia P.O. Box 10025,50700 Kuala Lumpur.
Customer Service Hotline: 603-2116 0228, E-mail: customer.mys@prudential.com.my

PART 2: LIFE ASSURED'S GENERAL INFORMATION

Name			
NRIC/Old IC/Passport/BC/Other		Contact Number*	
E-mail Address*		Name and Address of Employer	
Occupation			

Other Insurance Coverage	Name of Company / Insurer / Scheme	Policy / Membership Number	Sum Insured

PART 3: CLAIMANT'S DETAILS (IF OTHER THAN LIFE ASSURED)

CLAIMANT'S DETAILS	Claimant A	Claimant B	Claimant C	Claimant D
Name				
NRIC/Old IC/Passport/Other				
Correspondence Address*				
Contact Number*				
E-mail Address*				
Relationship to Life Assured				

***For personal details update (applicable for Assured only), please log on to https://pruaccessplus.prudential.com.my and update Change of Contact Details.**

PART 4: CLAIM INFORMATION

4.1 For Medical, Critical Illness, Total Permanent Disability and Others Claim if due to illness

4.1.1 Presented sign and symptom / diagnosis

4.1.2 How long has Life Assured been aware of the condition

4.1.3 First consultation with doctor to seek treatment ____ Day ____ Month ____ Year

4.1.4 Details of first and all doctors who have been consulted for the above condition.

Date of consultation	Name of doctor & Address

4.2 For Medical, Personal Accident and Total Permanent Disability Claim if due to accident

4.2.1 Date & Time of accident		Day		Month		Year	am/pm
4.2.2 Place of accident							
4.2.3 Detailed description of accident							
4.2.4 First consultation with doctor to seek treatment		Day		Month		Year	
4.2.5 Last working date prior to Disability		Day		Month		Year	
4.2.6 Date returned to work		Day		Month		Year	

4.3 Further information for Total Permanent Disability Claim

	Prior to suffering from disability	Current employment status
4.3.1 Occupation		
4.3.2 Name and Address of Employer		
4.3.3 Please describe in detail the exact duties performed		
4.3.4 Are you medically boarded out?		

4.3.5 Are you currently confined to: ☐ Bed-Ridden ☐ Home ☐ Wheel Chair Bound ☐ Able to walk with Aid

4.4 For Death Claim

4.4.1 Date & Time of death		Day		Month		Year	am/pm
4.4.2 Place of death							
4.4.3 Cause of death	☐ Illness	☐ Accident	☐ Suicide	☐ Others, please specify:			
4.4.4 If due to accident, please provide date and time of accident		Day		Month		Year	am/pm

4.4.5 Had the deceased suffered any illness previously? ☐ YES ☐ NO If YES, please provide details in below

Date of consultation	Name of doctor	Address	Telephone Number

4.4.6 Marital Status at point of death ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower

4.4.7 Deceased's surviving family member(s) ☐ Spouse ☐ Father ☐ Mother ☐ Child(ren)_____person(s)

4.4.8 Has the deceased left a Will or Testament? ☐ YES ☐ NO

PART 5: CLAIM REQUIREMENT CHECKLIST

NOTE: The following list serves as a guide for basic requirements. PAMB reserves the right to request or to view other relevant supporting document and information or the original of copied document whenever necessary.

CLAIM TYPE		Requirement List No. (Refer to Page 5)							
Hospitalisation / Day Care Surgery									
☐ Hospitalisation / Day Care Surgery		1a	3	4	6	12	13		
☐ Overseas Treatment		1a	3	4	6	10	11		
☐ Partially Settled by Other Insurers		1a	3	4	6	9			
☐ Surgical & Nursing Loan		1a	3	4	6				
Outpatient Treatment Benefit									
☐ Pre & Post Hospitalisation		3	4	10	11				
☐ Outpatient Cancer & Kidney Dialysis / Dengue Fever Treatment		2	3	4	10	11			
☐ Emergency Treatment of Accidental Injury		2	3	4	10	11	12	13	
☐ Home Nursing Care		3	4	10	11	24	25	26	
Allowance Benefit									
☐ Hopitalization Benefit / Allowance		1a	5						
☐ Well Being Benefit		1a	5	6					
Deductible Accumulation									
☐ Deductible Accumulation		1a	5						
Personal Accident									
☐ Accident Medical Reimbursement (AMR)		2	3	4	6	10	12	13	
☐ Weekly Indemnity (WI)		1b	6	7	10	12	13		
☐ Accidental Disablement		1b	6	8	10	12	13	17	
Critical Illness									
☐ Crisis Cover		1c	6	17					
☐ Payor / Waiver		1c	6	17	20				
☐ Crisis Cover Inccome		Not Applicable							
Total and Permanent Disability									
☐ Total and Permanent Disability / Long Term Care Benefit		1d	6	13	17	22	23		
☐ Total and Permanent Disability Instalment Benefit		1e							
☐ Payor / Waiver		1d	6	13	17	20	22	23	
Death / *Kematian*									
☐ Death	☐ (a) For Natural Death	1f	17	19	20	27			
☐ Spouse / Parent Payor / Waiver	☐ (b) For Accident or Suicide	1f	14	15	16	17	19	20	27
Others									
☐ Neonatal Jaundice		1g	5	6					
☐ Incubation / Intensive Care Unit / High Dependency Unit		1g	5						
☐ Congenital Conditions	☐ (a) For Infant Care	1h	3	4	6				
	☐ (b) For **PRU**lady	1h	6						
☐ Pregnancy / Maternity Complication	☐ (a) For Infant Care	1i	6	18	21				
	☐ (b) For **PRU**lady	1i	6	18	21				
	☐ (c) For Medical Rider	1i	3	4	6	18	21		
☐ Life Stage / Life Change Benefit		21							
☐ Snatch Theft Benefit		13							
☐ Female Carcinoma-in-situ / Recovery Benefit		1c	6						
☐ Infectious Disease Benefit		1j	5	6					
☐ Essential Child Benefit		1k	6	17					

Requirement List

- ☐ 1. Doctor's Statement:
  - (a) Medical Claim [Doc ID: 11601007]
  - (b) Personal Accident Claim [Doc ID 11601004]
  - (c) Critical Illness Claim (Please refer to Critical Illness Claim-Doctor's Statement Reference List for covered condition)
  - (d) Total and Permanent Disability Claim [Doc ID 11601013]
  - (e) Total and Permanent Disability Instalment Benefit [Doc ID 11601070]
  - (f) Death Claim [Doc ID 11601010]
  - (g) Paediatrician [Doc ID 11601087]
  - (h) Congenital Condition Claim [Doc ID 11601059]
  - (i) Pregnancy Complication Claim [Doc ID 11601060]
  - (j) Infectious Disease Benefit Claim [Doc ID 11601111]
  - (k) Essential Child Claim [Doc ID 11601120]
- ☐ 2. Accident / Event date, circumstances of illness / accident, extent of diagnosis / injuries and treatment details certified by the treating doctor on the receipt(s)
- ☐ 3. Original final bills / tax invoices with itemized breakdown details
- ☐ 4. Original receipts including deposit receipt **[Please complete List of Original Receipt]**
- ☐ 5. Copy of admission final bills / tax invoices with itemized breakdown details
- ☐ 6. Copy of tests results: Histopathology, X-ray, MRI, CT scan, ultrasound, blood test, visual acuity, audiogram report and all other lab test report
- ☐ 7. Medical certificate
- ☐ 8. Photograph showing injury / amputation for one full body and one showing the affected body part (where applicable)
- ☐ 9. Copy of settlement letter from other insurers
- ☐ 10. Medical report and medical bills translated in English (for overseas treatment)
- ☐ 11. Copy of passport indicating evidence of travel (for overseas treatment)
- ☐ 12. Copy of driving license (for road traffic accident)
- ☐ 13. Copy of police report (where applicable)
- ☐ 14. Police detailed investigation report
- ☐ 15. Post mortem report / autopsy
- ☐ 16. Toxicology report
- ☐ 17. Copy of Life Assured or Claimant 's NRIC or passport
- ☐ 18. Copy of Birth Certificate
- ☐ 19. Certified True Copy of Death Certificate by PAMB Branch Executive/ BDE/ RDM/Bank Branch Manager
- ☐ 20. Proof of relationship
- ☐ 21. Supporting document such as copy of: Birth Cert, Marriage Cert, Sale & Purchase Agreement, Spouse Death Cert etc.
- ☐ 22. Copy of letter medically boarded out from employer (where applicable)
- ☐ 23. Copy of confirmation letter from SOCSO (where applicable)
- ☐ 24. Recommendation letter from treating doctor for home nursing care
- ☐ 25. Copy of nursing qualifications certificate of the nurses
- ☐ 26. Breakdown charges detailing the time and period of the home nursing care services rendered per day
- ☐ 27. For death abroad: Report of death abroad from National Registration Department & Malaysian Embassy in country where death occurred, proof of transportation of corpse to Malaysia translated to English by a certified translator

List of ORIGINAL RECEIPT(s) submitted (including Deposit/Refund/Final Receipt(s)). Please paste on A4 paper according to receipt date.

Receipt Date	Receipt No.	Receipt Amount	Receipt Date	Receipt No.	Receipt Amount

Note: If space provided is insufficient, please continue on separate sheet of paper and firmly attach it to this form. **Total**

Special Instruction: Please indicate the Policy Number / Benefit to utilize in order of priority.

1.
2.
3.

Remarks (if any):

PART 6: STATEMENT OF DECLARATION

1. I/We hereby declare that I/We am/are authorised to make this claim and the information provided in this form is true and that the insured life of the claims concerned in this form ("Insured Life") has not suffered from any pre-existing condition at the time this policy was taken up.

2. I/We hereby agree that PAMB shall be at the liberty to deny liability or recover any amounts paid, if any part of the information is incomplete, untrue or incorrect.

3. I/We understand and agree to the following Data Privacy Declaration:
   (a) any personal data collected or held by PAMB (whether given now or subsequently to PAMB) can be processed and used to process this application, data matching, fraud detection and prevention, discharging PAMB's duties as an insurer, and communicating with me/us for any of these purposes ("Purposes");
   (b) To achieve these Purposes, PAMB (and any third party appointed by PAMB) can transfer and disclose to third parties such as reinsurers, claims investigator companies, other insurers, industry associations, hospitals, clinics, doctors, PAMB's intermediaries, individuals or entities within PAMB and Prudential plcs's group of companies, and other third party service providers PAMB has appointed. As some of these third parties are not located in Malaysia, PAMB can transfer the personal data to places outside of Malaysia;
   (c) I/We understand that I/we have a right to get access and request for correction of any personal data held by PAMB. Such requests can be made at PAMB's Customer Service Centre;
   (d) This Data Privacy Declaration can be revised from time to time, of which the notice of any such revision can be given on PAMB's corporate website or by such other means of communication deemed suitable by PAMB.

4. PAMB is authorised by me/us and the Insured Life to ask for medical information from any doctor, medical specialised, hospital or clinic that has any records or knowledge of the Insured Life's health and to gather information from any person (includes an individual, any company, society, insurer, organisation, institution) on any relevant information to do with the Insured Life. A copy of this authorisation will be as valid as the original and be legally binding to anyone who takes over any of my/our rights, as well as the rights of the Insured Life.

5. In relation to the personal data relating to another individual ("Data Subject"), I/We represent and warrant that:
   (a) I/We have obtained the Data Subject's consent to provide the personal data to PAMB; and
   (b) I/We have informed the Data Subject about the Data Privacy Declaration and the Data Subject understood and has agreed and authorised PAMB to process, use, disclose and transfer the personal data in accordance with the Data Privacy Declaration.

Authorization for Medical Report Collection

I/We hereby authorized _____ (IC No:_____) to collect my/our medical report on my/our behalf/behalves and then to submit the medical report to PAMB. I/We shall not hold PAMB accountable or liable in any way for any unauthorized access to or disclosure of, the information in the medical report, or for any unauthorized act relating to such information, conducted by the earlier-named person.

Name:

NRIC / Passport No. :

Signature of **Assured or Assignee**
* If assured/assignee is entity, kindly include entity stamp with name and designation of the authorised person signatory.

(If other than Assured or Assignee)

Name:

NRIC / Passport No.:

Signature of Claimant A

Name:

NRIC / Passport No.:

Signature of Claimant B

Name:

NRIC / Passport No.:

Signature of Claimant C

Name:

NRIC / Passport No.:

Signature of Claimant D

PART 7: STATEMENT OF WITNESS

I hereby certify all the above signatures were made in my presence.

Note: The Witness must be at least 18 years of age and cannot be one of the signees of this form.

Witness's Name:

NRIC/ Passport No:

Address:

Signature of **Witness**

APPLICATION FOR DIRECT CREDIT

Instruction: To be completed in DARK BLACK ink only and tick the boxes as appropriate.

Proposal/Policy Number

1. | 2. | 3.

4. | 5. | 6.

Application Date

Proposer/Assured's Name

Life Assured's Name

Agent/Bank/Prudential Assurance Malaysia Berhad Representative's Code

Agent/Bank/Prudential Assurance Malaysia Berhad Representative's Name/

Agent/Bank/Prudential Assurance Malaysia Berhad Representative's Contact Number/

Important Notes:

1. This application for Direct Credit Facility ("application") is only allowed for a valid bank account with a licensed financial institution in Malaysia that participates in the Interbank GIRO (IBG) payment system ("Account").
2. Prudential Assurance Malaysia Berhad ("PAMB") may approve this application to grant the Direct Credit Facility ("Facility") in its absolute discretion. The Payee will be informed in writing if PAMB approves this application.
3. In this form, "Payee" is referring to the proposer/assured/policy owner of the Proposals and Policies, or the person entitled to receive monies pursuant to the Proposal and Policy.
4. Please complete the Direct Credit section for arrangement for all the payouts from the policies listed in this form to be credited to the payee's selected bank account. PAMB will pay all these payouts into the payee's bank account that is registered with us. Otherwise, PAMB may consider relying on digital service or product, such as DuitNow to pay these payouts to the payee, only if such service or product is made available. If PAMB is not able to pay the monies to the payee within a year from the date the monies first become payable, the monies will be regarded as unclaimed monies. If so, PAMB is required to lodge the unclaimed monies with Jabatan Akauntan Negara Malaysia.

PART 1: BANK ACCOUNT DETAILS (as appeared in the bank passbook or statement)

Bank Name		Applicant's Name	
Account No.		Account Type *Tick [√] where appropriate	[ ] Conventional [ ] Islamic
NRIC No. (New)/NRIC No. (Old)		Passport/Police/Army/Company Registration No./	

PART 2: STATEMENT OF DECLARATION

In consideration of PAMB approving this application, I/we, who am/are also the Payee, hereby agree and declare that:

1. PAMB shall pay and credit the relevant monies payable pursuant to the Proposal and Policy ("Monies") into the Account;
2. PAMB shall continue to pay/credit the Monies into the Account until and unless PAMB receives a written instruction from the Payee to revoke the authority given to PAMB pursuant to this application or PAMB approves a new application to change the Account details provided in this application, at least one (1) month before the next payment date;
3. PAMB shall not be held liable for any losses that I/we may suffer or have suffered, whether directly or indirectly, if for any reason PAMB is unable or delayed to pay and credit the Monies into the Account through no fault of PAMB, including but not limited to, the payment being rejected by the financial institution due to incorrect Account details;
4. I/We agree to immediately refund to PAMB in full the Monies which is paid by mistake or which I/we;
5. PAMB is kept harmless and fully indemnified against any and all actions, claims, proceedings, costs (including legal costs on solicitor and client basis) and damages, including any compensation paid by PAMB to settle such claim, that may howsoever arise from or be incidental to my/our instruction pursuant to this application. This authorization and indemnity contained in this application shall be binding upon my/our respective successors-in-title, executors, administrators, personal representatives and/

6. I/We understand and agree to the following Data Privacy Declaration:

a) Any personal data collected or held by PAMB (whether given now or subsequently to PAMB) can be processed and used to process this application, for data matching, fraud detection and prevention, discharging PAMB's duties as an insurer, updating PAMB's records, marketing and promotion of other financial products and services by PAMB, group of companies of PAMB and Prudential plc, as well as communicating with me/us for any of these purposes ("Purposes");

b) To achieve these Purposes, PAMB (and any third party appointed by PAMB) can transfer and disclose the personal data to third parties such as financial institutions, reinsurers, claims investigator companies, other insurers, industry associations, PAMB's intermediaries, individuals or entities within PAMB, group of companies of PAMB and Prudential plcs, as well as other third party service providers PAMB has appointed. As some of these third parties are not located in Malaysia, PAMB can transfer the personal data to places outside of Malaysia;

c) I/We understand that I/we have a right to get access and request for correction of any personal data held by PAMB. Such requests can be made at PAMB's Customer Service Centre; and

d) This Data Privacy Declaration can be revised from time to time, of which the notice of any such revision can be given on PAMB's corporate website or by such other means of communication deemed suitable by PAMB.

Signature of **Applicant**
Name
NRIC/Passport No.

PART 3: STATEMENT OF WITNESS

I hereby certify the above signature(s) was/were made in my presence.

Note: The Witness must be at least 18 years of age and cannot be a named contingent assured/named nominee/trustee.

Signature of **Witness**
Witness's Name
NRIC/Passport No.