PRU LIFE U.K.

CLAIMANT STATEMENT
PRULADY

Write legibly and fill out all necessary information completely.
If the question is not applicable, write "NA".

Please check the benefit stated in your Policy Data Page applicable to the claim.	**AGENT INFORMATION**
☐ CORE BENEFIT ☐ OPTIONAL BENEFIT	**Agent Name and Branch** **Mobile Number** **Email Address**

Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim.

POLICY INFORMATION

Policy Number	**Name of Policyowner** *(Last Name, First Name, Middle Name)*

INSURED INFORMATION

Name of Insured *(Last Name, First Name, Middle Name)*				**Relationship to the Policyowner**	
Date of Birth (mm/dd/yy)	**Age**	**Gender** ☐ Male ☐Female	**Civil Status**	**Place of Birth**	**Citizenship**
Address *(Number, Street)*				**City/Province** **Zip Code**	
Phone Number *(Residence)*		**Mobile Number**		**Personal E-mail Address**	
Occupation/Position/Type of Work		**Phone Number** *(Business)*		**Work E-mail Address**	

Do you have any existing insurance policy with Pru Life UK or another company? ☐ Yes ☐ No
If "yes", kindly fill out the details below (Please use a separate sheet if needed.):

Company	Policy Details	Date Issued and Status (mm/dd/yy)	Benefit Amount

HOSPITALIZATION DETAILS

Hospital Name	
Hospital Address	
Admission Number	**Ward/Room Number**
Date of Admission/Consultation (mm/dd/yy)	**Date of Discharge** (mm/dd/yy)
Number of Days of Confinement	**Final Diagnosis**

Every question must be distinctly and completely answered by the claimant to expedite claim processing.
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HEALTH HISTORY

Describe fully the extent and nature of your illness	
When did you first consult a medical practitioner in connection with your illness?	
What symptom/s did you experience which resulted in your hospitalization/consultation?	
When did the symptom/s begin?	
Have you previously suffered or received any treatment for a similar or related illness? ☐ Yes ☐ No If "yes" please give details.	

Confinement /consultation history for the past 5 years (Please use a separate sheet if needed):

Date (mm/dd/yy)	**Hospital/Clinic**	**Physician**	**Diagnosis**	**Treatment**

Please provide details of Doctors or Specialists you have consulted in connection with your illness on the space provided below.
(Please use a separate sheet if needed)

Date (mm/dd/yy)	**Name**	**Address**	**Findings**	**Duration**

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Have any of your blood relatives suffered from a similar or related illness? ☐ Yes ☐ No
If "yes", please give full details (Please use a separate sheet if needed):

Relationship	Nature of Illness	Date of Diagnosis (mm/dd/yy)

Do you smoke cigarettes? ☐ Yes ☐ No
If "yes", please give full details.

What is your daily consumption?	
How long have you been smoking?	

MODE OF RELEASE OPTION
In case this claim is approved, I prefer my payout released to me through:

☐ **Fund Transfer**

1. Fund transfer to the following accredited banks are free of charge: **Bank of the Philippine Islands (BPI), Metropolitan Bank and Trust Company (MBTC), The Hong Kong and Shanghai Banking Corporation (HSBC), Security Bank (SB), Citibank, and Standard Chartered Bank (SCB), Banco De Oro (BDO), Philippine Bank of Communication (PBCOM), China Bank.**
2. Fund Transfer to non-accredited banks is subject to bank charges.
3. Insured or Beneficiary/Beneficiaries of minor age are not eligible for the fund transfer option.

Account Holder's Name	**Currency** ☐ Dollar ☐ Peso
Name of Bank	**Account Number and Type**
Bank Address/Branch	**Swift Code/Routing Number**

☐ **Check Pick-up**

☐ Pru Life UK Head Office: 9F Uptown Place Tower 1, 1 East 11th Drive, Uptown Bonifacio, 1634 Taguig City, Metro Manila, Philippines

☐ Preferred Pru Life UK Branch

Preferred Pru Life U.K. Branch Address

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By selecting the above option and in consideration of any payment received from Pru Life Insurance Corporation of U.K. ("Pru Life UK") pursuant to a claim hereunder, I, for myself and on behalf of my heirs, assigns and successors-in-interest, hereby fully, completely, and absolutely release, discharge, and hold free and harmless Pru Life UK and any of its parent companies, affiliates, subsidiaries, directors, officers, employees and successors-in-interest from any and all claims, demands, liabilities, and causes of action, in law or in equity, arising from or connected with this claim or any payment in relation thereto. I hereby warrant that this declaration may be pleaded as an absolute bar to any litigation or suit that has been or may be brought in connection with this claim, and I promise to defend the right of Pru Life UK and any of its parent companies, affiliates, subsidiaries, directors, officers, employees and successors-in-interest, and all other persons having interest therein and thereby, and to fully answer all costs and expenses, including attorney's fees, interests, penalties and other damages arising from such litigation or suit to which Pru Life UK may be entitled, including all other persons having interest therein or thereby.

I further warrant that I fully understand the foregoing and the implications thereof and that I have executed this release, waiver, and quitclaim voluntarily and out of my own free will.

DECLARATION

The undersigned hereby makes a claim on the insurance of the Insured with Pru Life UK and agrees that the written statements and affidavits of the physicians who attended to or treated the Insured and all other documents required herein, shall constitute and be considered as proofs of his/her medical condition, and further agrees that the furnishing of this Claimant Statement or any other supplemental form by Pru Life UK shall not constitute nor be considered as 1) an admission that there was any insurance in force on the life in question or of liability for payment of any benefit provided in any insurance policy issued by it; or 2) a waiver of any of its rights or defenses.

I hereby declare that all answers given by me in this Claimant Statement are, to the best of my knowledge and belief, true and complete.

CLAIMANT CERTIFICATE OF AUTHORIZATION

This is to authorize Pru Life UK and/or its duly authorized representatives to secure any and all information or records in relation to the Insured that are available from any physician or medical practitioner, or government or private hospitals, clinics, medical facilities or offices. This authorization is being made in connection with a claim on the insurance policy or policies issued by Pru Life UK to the Insured.

It is understood that by virtue of this authorization, any such physician, medical practitioner, government or private hospital, clinic, medical facility or office or any and all members of its staff shall be released from any responsibility or obligation in connection with the release of such records or information.

A facsimile or reproduction of this authorization shall be as effective, valid and binding as the original.

Pru Life UK may transfer, disclose or communicate any information relating to the policy or policies identified herein to any of the branches, subsidiaries, affiliates, agents and representatives of Pru Life UK, Prudential Corporation Asia, Prudential plc and third parties selected by any of them, to be used for the purpose of offering, soliciting or providing any product or service or for any other purpose such as data processing and storage or anti-money laundering monitoring, review and reporting. In addition, Pru Life UK, its offices, branches, subsidiaries, affiliates, agents and representatives may transfer, disclose and use any such information as may be required by law or regulation.

Signature Over Printed Name of Insured	**Place and Date Signed** (mm/dd/yy)
Signature Over Printed Name of Policyowner (if different from Insured)	**Place and Date Signed** (mm/dd/yy)
Signature Over Printed Name of Witness	**Place and Date Signed** (mm/dd/yy)

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PRU LIFE U.K.

PRULADY
STANDARD DOCUMENTARY REQUIREMENTS

(All documents must either be in Original or Certified True Copy)
Upon submission of complete basic requirements, Claims and Benefits Services may require additional documents or information depending on the case.

☐ **CLAIMANT STATEMENT**

This must be clearly and completely filled out by the Insured.

If the Insured is unable to sign Claimant Statement:

Thumb mark is acceptable, if:

- Countersigned by the spouse, if married;
- Countersigned by his/her children of legal age, if the Insured is a parent; or
- Countersigned by the parent (or next of kin in the absence of Parent), if the Insured is single.

If the Insured and Policyowner are different (no change in benefit / no effect upon approval of claim):

- Policyowner shall sign the Claimant Statement; and
- If Policyowner is a company or institution, the authorized signatory or representative stated in the updated board resolution of the company or institution shall sign the Claimant Statement.

☐ **POLICY CONTRACT (consists of the Application for Insurance, the Policy Data Page, the Sales Illustration Form and Policy Booklet)**

In case of loss, submit "Agreement Pertaining to Loss or Destruction of Policy" signed by the Insured.

☐ **COMPLETE MEDICAL RECORDS**

This must be duly certified by the issuing hospital/institution.

- Admission and Discharge Summary; and
- Clinical Summary and Abstract.

☐ **TWO VALID IDENTIFICATION CARDS OF INSURED**

These must be clear photocopies with 3 specimen signatures and stamp indicating that the Original ID was seen.

☐ **TWO VALID IDENTIFICATION CARDS OF POLICYOWNER**

This is only required if the Insured is different from the Policyowner. These must be clear photocopies with 3 specimen signatures and stamp indicating that the Original ID was seen.

☐ **TWO VALID IDENTIFICATION CARDS OF AUTHORIZED REPRESENTATIVE OF COMPANY OR INSTITUTION**

This is only required if Policyowner is a company or institution. These must be clear photocopies with 3 specimen signatures and stamp indicating that the Original ID was seen.

☐ **REASON FOR LATE FILING OF CLAIM**

If claim is filed beyond 90 days from discharge date

IF POLICY IS LESS THAN TWO YEARS FROM THE EFFECTIVITY DATE OR DATE OF APPROVAL OF LAST REINSTATEMENT

☐ COMPLETE MEDICAL RECORDS

This must be duly certified by the issuing hospital/institution.

- Admission and Discharge Summary Consultation Record, diagnostic results (including APE), confinement records before policy effectivity date or date of last reinstatement, increase of coverage or addition of the benefit. (Certified True Copy)
- History Sheet: Contains chief complaint, personal, and family history (past and present)

IF THE INSURED EVENT HAPPENED OUTSIDE THE PHILIPPINES

☐ All forms & proofs of claim obtained outside the Philippines must be in English and duly authenticated by the Philippine Embassy or Consul of the country where the event happened.

IF CLAIMANT IS OUTSIDE THE PHILIPPINES

☐ Signed Claimant Statement authenticated by the Philippine Embassy or Consul.

LIST OF VALID IDs

- Passport
- Driver's License
- Professional Regulations Commission (PRC) ID
- Police Clearance
- Postal ID
- Voter's ID
- Photo-Bearing Barangay ID/Certification
- GSIS e-Card
- SSS Card
- Philhealth Card
- Senior Citizen's Card
- Overseas Workers Welfare Administration (OWWA) ID
- OFW ID
- Seaman's Book
- Alien Certificate of Registration/Immigrant Certificate of Registration
- Government Office ID (e.g. AFP, Home Development Mutual Fund, Department of Education IDs) and IDs issued by government instrumentalities
- Photo-Bearing ID/Certification from the National Council for the Welfare of Disabled Persons (NCWDP)
- Department of Social Welfare and Development (DSWD) photo-bearing ID/Certification
- Firearms License
- ID issued by the Bureau of Internal Revenue
- Photo-Bearing Credit Card
- Photo-Bearing Health Card issued by Health Maintenance Organizations

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PRU LIFE U.K.

PRULADY
ADDITIONAL REQUIREMENTS

(All documents must either be in Original or Certified True Copy)
Upon submission of complete basic requirements, Claims and Benefits Services may require additional documents or information depending on the case.

CORE BENEFIT

Dilatation & Curettage

- ☐ ATTENDING PHYSICIAN'S STATEMENT
- ☐ Biopsy and/or Histopathology Result
  Accomplished by OB-Gynecologist
- ☐ Record of Operation

Facial Reconstructive Surgery and Skin Grafting

- ☐ ATTENDING PHYSICIAN'S STATEMENT
  Accomplished by Surgeon
- ☐ Body Surface Area Burn Record
- ☐ Proof of Accident
- ☐ Record of Operation

Female Invasive Cancer

- ☐ ATTENDING PHYSICIAN'S STATEMENT
  Accomplished by Oncologist
- ☐ Biopsy and/or Histopathology Result

Hysterectomy

- ☐ ATTENDING PHYSICIAN'S STATEMENT
  Accomplished by Oncologist
- ☐ Biopsy and/or Histopathology Result
- ☐ Record of Operation
- ☐ Ultrasound Result

Loss of Independent Existence

- ☐ ATTENDING PHYSICIAN'S STATEMENT
  Accomplished by Neurologist
- ☐ CT scans
- ☐ MRI Result/s
- ☐ Neurologic Exam result

Systemic Lupus Erythematosus

- ☐ ATTENDING PHYSICIAN'S STATEMENT
  Accomplished by Rheumatologist
- ☐ 24-Hour Urine albumin or protein
- ☐ CBC with quantitative platelet count
- ☐ Glomerular Filtration Rate (GFR) Test Result
- ☐ Lupus Panel Result

PRU LIFE U.K.

PRULADY
ADDITIONAL REQUIREMENTS

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Upon submission of complete basic requirements, Claims and Benefits Services may require additional documents or information depending on the case.

OPTIONAL BENEFIT

MATERNITY COMPLICATION

Death of Fetus

- ☐ ATTENDING PHYSICIAN'S STATEMENT
  Accomplished by OB-Gynecologist
- ☐ Certificate of Fetal Death
- ☐ Obstetric Records
- ☐ Ultrasound Result after 25 weeks of pregnancy

Death of Infant

- ☐ ATTENDING PHYSICIAN'S STATEMENT
  Accomplished by OB-Gynecologist
- ☐ Certificate of Death
- ☐ Certificate of Live Birth of Child
- ☐ Record of Operation

Disseminated Intravascular Coagulation

- ☐ ATTENDING PHYSICIAN'S STATEMENT
- ☐ Hematology Results
- ☐ Obstetric Records

Ectopic Pregnancy

- ☐ ATTENDING PHYSICIAN'S STATEMENT
  Accomplished by OB-Gynecologist
- ☐ Obstetric Records
- ☐ Record of Operation
- ☐ Ultrasound Result

CONGENITAL ANOMALY

Down's syndrome

- ☐ ATTENDING PHYSICIAN'S STATEMENT
  Accomplished by Neurologist
- ☐ Admission & Discharge record on delivery of child
- ☐ Physical and Mental Development Examination Result
- ☐ Valid Identification card of child and birth certificate of child

Spina Bifida

- ☐ ATTENDING PHYSICIAN'S STATEMENT
  Accomplished by Neurologist
- ☐ CT scan
- ☐ MRI
- ☐ Valid Identification card of child and birth certificate of child
- ☐ Ultrasound
- ☐ X-ray

Tetralogy of Fallot

- ☐ ATTENDING PHYSICIAN'S STATEMENT
  Accomplished by Cardiologist
- ☐ Chest X-ray
- ☐ Echocardiogram
- ☐ Valid Identification card of child and birth certificate of child

Transposition of Great Vessel

- ☐ ATTENDING PHYSICIAN'S STATEMENT
  Accomplished by Pediatric Cardiologist
- ☐ Chest X-ray
- ☐ Echocardiogram
- ☐ Valid Identification card of child and birth certificate of child