CLAIMANT STATEMENT
DISABILITY, DAILY HOSPITAL INCOME, SURGICAL EXPENSE BENEFIT, ACCIDENTAL MEDICAL EXPENSE REIMBURSEMENT

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

PRU LIFE U.K.

PRU LIFE INSURANCE CORPORATION OF U.K.
9/F Uptown Place Tower 1, 1 East 11th Drive, Uptown Bonifacio,
1634 Taguig City, Philippines
Customer helpdesk: (632) 8683 9000, (632) 8884 8484, (632) 8887 LIFE
within Metro Manila, 1 800 10 PRULINK for domestic toll-free
Email: contact.us@prulifeuk.com.ph • Website: www. prulifeuk.com.ph

Please check the benefit stated in your Policy Data Page applicable to the claim.

- ☐ ACCIDENTAL MEDICAL EXPENSE REIMBURSEMENT
- ☐ ACCIDENTAL DISABLEMENT/ DISMEMBERMENT
- ☐ DAILY HOSPITAL INCOME
- ☐ DANGEROUS SPORTS COVERAGE
- ☐ INTENSIVE CARE UNIT
- ☐ LONG TERM HOSPITALIZATION
- ☐ MURDER AND ASSAULT
- ☐ PAYOR WAIVER IN THE EVENT OF TPD OF PAYOR
- ☐ SURGICAL EXPENSE REIMBURSEMENT
- ☐ TOTAL & PERMANENT DISABILITY
- ☐ WAIVER OF PREMIUM DUE TO TPD

AGENT INFORMATION

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 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)*

LIFE INSURED/LIFE ASSURED INFORMATION

Name of Life Insured/Life Assured *(Last Name, First Name, Middle Name)*

Date of Birth (mm/dd/yy)	**Age**	**Gender** ☐ Male ☐ Female	**Civil Status**	**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**
Employer Name		**Employer Address**		

Do you have any other existing insurance policy with Pru Life UK or another company? ☐ Yes ☐ No
If "yes", kindly fill out the details below:

Company	Plan Name	Policy Number	Plan Benefits	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 *(Only fill out if one of your policies is less than two years from policy effective date, date of last reinstatement, addition of rider, or increase of benefit amount.)*

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

FOR INTENSIVE CARE UNIT BENEFIT (Only fill out if applicable)

Date Admitted (mm/dd/yy)	Date Discharged (mm/dd/yy)	Reason for Admission	Number of Days	Doctor in Charge

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FOR SURGICAL EXPENSE BENEFIT (Only fill out if applicable)

Operation Date (mm/dd/yy)	Type of Operation	Post-operation Diagnosis	Name of Surgeon	Name of Anesthesiologist

FOR ACCIDENT BENEFIT ONLY (Only fill out if applicable)

Date and Time of Accident (mm/dd/yy)	Place of Accident

Cause of Accident/Injury

Extent of Injury

Were you at work/official business when the accident/injury happened? ☐ Yes ☐ No

Please provide details of the accident/injury. Use separate sheet if necessary.

RECEIPT SUMMARY (Only fill out if applicable)

Please use separate sheet if necessary.

Date of Receipt (mm/dd/yy)	OFFICIAL RECEIPT NO.	Particulars	Amount

CLAIMANT STATEMENT
DISABILITY, DAILY HOSPITAL INCOME, SURGICAL EXPENSE BENEFIT, ACCIDENTAL MEDICAL EXPENSE REIMBURSEMENT

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If the question is not applicable, write "NA".

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**
   ☐ **Standard Chartered Bank (SCB)**
   ☐ **Banco De Oro (BDO)**
   ☐ **Philippine Bank of Communication (PBCOM)**
   ☐ **China Bank**
   ☐ **Robinson's Bank**
   ☐ **Eastwest Bank**

2. Fund Transfer to non-accredited banks is subject to bank charges.
3. A Policyowner/Life Insured/Life Assured or Beneficiary/Beneficiaries of minor age (whichever is applicable) must have an existing individual bank account for the fund transfer option.
4. Account must be under the name of the Policyowner/Life Insured/Life Assured or Beneficiary/Beneficiaries (whichever is applicable).
5. Please provide proof of ownership of bank account.

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

☐ **Check Pick-up**

Claimant Name _____

Preferred Business Center _____

Disclaimer: Please expect additional 3-5 days for the releasing of check

By selecting the chosen mode of release 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.

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DECLARATION

The undersigned hereby makes a claim on the insurance of the Life Insured/Life Assured with Pru Life UK and agrees that the written statements and affidavits of the physicians who attended to or treated the Life Insured/Life Assured 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 Life Insured/Life Assured 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 Life Insured/Life Assured.

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.

Purpose Statement:
We will process the information you have provided in this form for the purpose of handling your request in accordance with applicable privacy laws and regulations. During processing, we may share the information you provided to our authorized data processors, including couriers and contractors for anti-money laundering systems, photocopying, scanning, indexing and printing services. We may share your information with governmental and other regulatory authorities, or self-regulatory bodies in various jurisdictions as required or allowed by applicable laws and regulations. Any information collected may be retained by Pru Life UK and our authorized data processors until ten (10) years from the date of termination of the policy.

You may revisit our privacy policy through our website at (https://www.prulifeuk.com.ph/en/footer/privacy-policy/). For data privacy concerns, please contact our Data Privacy Officer at:

Telephone: (632) 8887 5433 for Metro Manila, 1 800 10 7785465 via PLDT landline for domestic toll-free

Email: dpo@prulifeuk.com.ph

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

Signature Over Printed Name of Witness	**Place and Date Signed** (mm/dd/yy)

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DISABILITY, DAILY HOSPITAL INCOME, SURGICAL EXPENSE BENEFIT, ACCIDENTAL MEDICAL EXPENSE REIMBURSEMENT STANDARD DOCUMENTARY REQUIREMENTS

PRU LIFE U.K.

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

☐ **CLAIMANT STATEMENT**

This must be clearly and completely filled-up by the Life Insured/Life Assured

If the Life Insured/Life Assured 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 Life Insured/Life Assured is a parent; or
- ☐ Countersigned by the Parent (or next of kin in the absence of Parent), if the Life Insured/Life Assured is single.

If the Life Insured/Life Assured and Policyowner are different (except PA stand-alone):

- ☐ Policyowner signs the Claimant Statement.
- ☐ If Policyowner is a company or institution, the authorized representative of the company or institution as stated in its updated board resolution shall sign the Claimant Statement.

☐ **ATTENDING PHYSICIAN'S STATEMENT/S**

This must be duly accomplished by the Physician/s who attended to the Life Insured/Life Assured.

- ☐ For loss of sight, APS must be accomplished by an Ophthalmologist.
- ☐ For loss of hearing, APS must be accomplished by an ENT.
- ☐ For loss of speech, APS must be accomplished by an ENT and Neurologist.

☐ **CLINICAL ABSTRACT FOR CONFINEMENT**

☐ **TWO VALID IDENTIFICATION CARDS OF LIFE INSURED/LIFE ASSURED**

☐ **TWO VALID IDENTIFICATION CARDS OF POLICYOWNER**

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

☐ **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/DATE OF APPROVAL OF LAST REINSTATEMENT OR ADDITION OF RIDER

☐ COMPLETE MEDICAL RECORDS

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

- ☐ Admission and Discharge Summary Consultation Record, diagnostic results (including Annual Physical Exam), confinement records before 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 INCIDENT IS DUE TO EXTERNAL CAUSES (Homicide, Suicide, Accident, Murder, etc.)

☐ Certified true copy of the Final Investigation report of Police Authorities or National Bureau of Investigation;

☐ Original or certified true copy of Sworn Statement or Affidavits on file of at least two witnesses to the incident or Affidavit of at least two persons cognizant of the circumstances surrounding Life Insured/Life Assured's violent death , injury, or disability;

☐ Certified true copy of Medico-Legal Report / Autopsy Report, if any;

☐ Driver's license and vehicle registration if Life Insured/Life Assured was driving a vehicle at the time of the accident;

☐ Duly certified copy of the Criminal Complaint filed in the court, if any, or Fiscal's Resolution, if any.

IF THE INSURED EVENT HAPPENED OUTSIDE THE PHILIPPINES

☐ All forms and 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.

☐ Medical records from a hospital located abroad do not require authentication by the Philippine Embassy located in such foreign country. Apostille mark or stamp for medical records is accepted.

IF CLAIMANT IS OUTSIDE THE PHILIPPINES

☐ Signed Claimant Statement authenticated by the Philippine Embassy or Consul; and

☐ If payment of proceeds is in check, Claimant must provide Special Power of Attorney (SPA) duly authorizing him/her, authenticated by the Philippine Embassy or Consul.

☐ Medical records from a hospital located abroad do not require authentication by the Philippine Embassy located in such foreign country. Apostille mark or stamp for medical records is accepted.

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

ACCIDENTAL MEDICAL EXPENSE REIMBURSEMENT

☐ INCIDENT REPORT FOR MINOR INCIDENT FROM THE LIFE INSURED/LIFE ASSURED OR ANY WITNESS /WITNESSES TO THE INCIDENT

☐ ORIGINAL OFFICIAL RECEIPTS RELATED TO TREATMENT OF INJURY (Expenses incurred within 30 days from date of accident)

☐ PHOTOCOPY OF PRESCRIPTION

DAILY HOSPITAL INCOME

☐ HOSPITAL STATEMENT OF ACCOUNT
This must show the following:
- ☐ Admission date and time; and
- ☐ Discharge date and time.

INTENSIVE CARE UNIT (ICU)

☐ HOSPITAL STATEMENT OF ACCOUNT
This must show the number of days stayed in ICU.

SURGICAL EXPENSE BENEFIT

☐ CERTIFIED TRUE COPY OF RECORD OF OPERATION

☐ DHI REQUIREMENTS

☐ ORIGINAL OFFICIAL RECEIPTS
- ☐ Surgeon's Fee
- ☐ Anesthesiologist's Fee
- ☐ Operating Room Fee
- ☐ Recovery Room Fee

TOTAL PERMANENT DISABILITY AND ACCIDENTAL DISABLEMENT

☐ **ACTIVITIES OF DAILY LIVING**

☐ **CERTIFIED TRUE COPY OF RECORD OF OPERATION,** if any

☐ **EMPLOYER'S CERTIFICATION**

☐ **NEUROLOGICAL EXAMINATION**

☐ **NOTARIZED AFFIDAVIT FROM LIFE INSURED/LIFE ASSURED OF TASKS PERFOMED BEFORE AND AFTER DISABILITY**

☐ **SSS CERTIFICATION ON TOTAL AND PERMANENT DISABILITY,** if any

FOR ACCIDENTAL DISMEMBERMENT/LOSS OF USE

☐ X-ray Result for Dismemberment of a limb / extremity

FOR LOSS OF SIGHT

☐ Light Perception

☐ Slit lamp result

☐ Visual Acuity

FOR LOSS OF HEARING

☐ Audiometry and sound-threshold Test Result

FOR LOSS OF SPEECH

☐ MRI of larynx

☐ MRI and/or CT scan of the Brain

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

These must be clear photocopies with stamp indicating that the Original ID was seen by witness.

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