UOB LADY CANCER CLAIM FORM

Policy Number: CL100007 **Policyholder: United Overseas Bank Limited**

DETAILS OF LIFE INSURED / CLAIMANT

1. LIFE ASSURED

Full Name:			
Address:			
NRIC No:		Contact No:	
Date of Birth:		Occupation:	
UOB Credit Card/Acc No:			

2. Type of claim *(Please indicate the type of claim you would like to file by putting a tick [√] in the appropriate box).*

▪ Malignant Cancer of the Breast		▪ Malignant Cancer of the Fallopian Tube	
▪ Malignant Cancer of the Cervix Uteri		▪ Malignant Cancer of the Ovary	
▪ Malignant Cancer of the Uterus		▪ Malignant Cancer of the Vagina/Vulva	

3. NATURE OF CLAIM

3.1 Please describe fully the extent and nature of illness.

3.2 Have you previously suffered from or received treatment for a similar or related illness? If yes, please give details.

3.3 Please provide the details of all doctors and specialists whom you have consulted in connection with your illness:

Name of doctor consulted	Address of Doctor	Date first consulted for this illness

3.4 Please provide details of your regular doctor and company doctor whom you have consulted for minor ailments (e.g. flu, cough, fever) :

Name of doctor consulted	Address of Doctor	Date first consulted for this illness

3.5 Please provide details of the hospital where you were treated: -

Name of Hospital	
Date of Admission and discharge date	
Reason for Admission	

3.6 Are you insured for similar benefits with any other company? If 'yes', please give full details:

Name of Insurer	
Amount of Benefit	

DECLARATION, AUTHORISATION AND CONSENT (To be signed by the Claimant):

(a) I hereby declare that the statements and answers given in this form are true and complete to the best of my knowledge and belief, and further, that I have not made any false or fraudulent statement, suppressed or concealed any facts. (b) I hereby expressly authorise and consent to: (i) any hospital, medical practitioner, clinic, any medical source and any insurance office to disclose to Prudential Assurance Company Singapore (Pte) Limited ("Prudential") or its appointed third party service providers, all information relating to me or the dependent, including my/our personal particulars, my/our medical records, and any information required; and (ii) Prudential collecting, using and disclosing the information set out in sub-section (i), above to any of the following persons whether in Singapore or elsewhere: (1) Prudential's holding companies, branches, representative offices, subsidiaries, related corporations or affiliates;(2) any of Prudential's contractors or third party service providers; and (3) the Policyholder and its appointed intermediary,for the purposes of claims assessment, policy servicing, statistical analysis, investigation of Prudential's representatives and monitoring undesirable sales practices. (c) I understand and agree that a photocopy of this authorisation shall be as valid as the original.

Signature of Life Assured

Date

Prudential Assurance Co. Singapore (Pte) Ltd (Reg. No. 199002477Z)
Enterprise Business, Claims. Singapore Post Centre Post Office, PO Box 399, Singapore 914014
Telephone: 1800-835-9733 Email: SGP.ES.Claims@prudential.com.sg

Name of Patient	NRIC / Passport No. of Patient

SECTION 2 MEDICAL SPECIALIST REPORT

Malignant Cancer of the Breast / Cervix Uteri / Uterus / Fallopian Tube / Ovary / Vagina / Vulva

(To be completed by the Life Assured's attending medical specialist)

Name of Specialist		MCR No.	
Field of Specialty			
Name of Medical Institution			

Part I

1. Date when patient first consulted you for the condition?		DD		MM		YY
2. When was the last consultation?		DD		MM		YY
3. What were the presenting symptoms when you first saw the patient?						
4. When did the above symptoms first present?		DD		MM		YY
5. Please provide exact diagnosis.						
6. What is/are the underlying cause(s)?						
7. Date of diagnosis.		DD		MM		YY
8. Date when patient / patient's next of kin was first informed of the diagnosis.		DD		MM		YY

Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**	Date

9. Please provide dates and details of investigation performed for the diagnosis. Kindly **attach copies** of all relevant objective test reports, which confirmed the diagnosis.							
10. Were you the doctor who first diagnosed the patient with this condition? Please circle.						Yes	No
11. If Yes to Question 10, over what period do your records extend?		From (dd/mm/yy)				To (dd/mm/yy)	
12. If you are not the first doctor who diagnosed the patient with this condition, please provide:							
a. Name and address of the doctor who first made the diagnosis or had treated the treated the patient for this condition.							
b. Date the diagnosis was made by the previous doctor.		DD		MM			YY
c. When was the referral made for the patient to see you?		DD		MM			YY
d. What was the reason for referral to see you? Please attach a copy of the referral letter.							
e. Please provide name and address of referral doctor.							
13. Please indicate the primary and exact anatomical site of the tumor							
14. Is the tumor malignant? Please circle.						Yes	No
a. If Yes to Question 14, please confirm if there is histological evidence of uncontrolled growth of malignant cells with invasion and destruction of normal tissue? Please circle. **(Please attach the histology report in Section 3 of this medical questionnaire.)**						Yes	No
b. If histological evidence is not available, please advise us the medical justification to establish the diagnosis of malignant tumor.							

Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**	Date

15. What is the staging of the tumor based on TNM Classification? If the tumor has no TNM Classification, please advise us the type of staging / grading system (e.g. RAI staging, Clark Level, FIGO system, etc.) used to stage the tumor and its equivalent classification in TNM staging system:		
a. Was the disease completely localized? Please circle.	Yes	No
b. Was there invasion of adjacent tissues? Please circle.	Yes	No
c. Were regional lymph nodes involved? Please circle.	Yes	No
d. Were there distant metastases? Please circle.	Yes	No
If Yes to Question 15(d), please provide full details, including site of metastases:		
16. Please circle your reply to Question (a) to (h) below if the tumor was histologically classified as any of the following?		
a. Was the diagnosis of tumor Benign?	Yes	No
b. Was the diagnosis of tumor Pre-malignant?	Yes	No
c. Was the diagnosis of tumor Carcinoma-in-situ?	Yes	No
d. Was the diagnosis of tumor classified as Cervical Dysplasia CIN-1, CIN-2 and CIN-3?	Yes	No
If Yes to Question 16(d), please state the exact Cervical Intraepithelial Neoplasia (CIN) category and if there is pathologic evidence of carcinoma in situ:		
e. Was the diagnosis of tumor having borderline malignancy?	Yes	No
f. Was the diagnosis of tumor having any degree of malignant potential?	Yes	No
g. Was the diagnosis of tumor having suspicious malignancy?	Yes	No
h. Was the diagnosis of tumor classified as neoplasm of uncertain or unknown behavior?	Yes	No

Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**	Date

17. Please circle your reply to Question (a) to (e) below, if the patient's condition is skin cancer, please confirm its type based on the following:		
a. Is the patient's condition malignant melanoma that has not invaded beyond the epidermis?	Yes	No
b. Is the patient's condition hyperkeratosis skin cancer?	Yes	No
c. Is the patient's condition basal cell skin cancer?	Yes	No
d. Is the patient's condition squamous cell skin cancer?	Yes	No
e. Is the patient's condition invasive melanoma of less than 1.5mm Breslow thickness, or less than Clark Level 3?	Yes	No
If Yes to Question 17(e), please provide details of size, thickness and depth of invasion. Please also state if there is any pathologic evidence of invasion beyond the epidermis or metastases to lymph nodes.		
18. Is the patient's condition prostate cancers histologically described as T1N0M0? Please circle.	Yes	No
If Yes to Question 18, please circle the exact stage T1 classification.	**T1a / T1b / T1c**	
19. Is the patient's condition thyroid cancer histologically described as T1N0M0? Please circle.	Yes	No
If Yes to Question 19, please state the size in diameter:		
20. Is the patient's condition urinary bladder cancer histologically described as T1N0M0? Please circle.	Yes	No
21. Is the patient's condition papillary micro-carcinoma of the bladder? Please circle.	Yes	No
If Yes to Question 21, please explain the medical justification to establish the diagnosis of papillary micro-carcinoma of the bladder:		
22. Is the patient's condition Gastro-Intestinal Stromal tumors (GIST) with mitotic count of less than or equal to 5/50 HPFs? Please circle.	Yes	No
If No to Question 22, please state the tumour TNM classification and its mitotic count in HPFs:		

Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**	Date

23. Is the patient's condition Chronic Lymphocytic Leukaemia less than RAI Stage 3? Please circle.	Yes	No
If No to Question 23, please state the type of leukaemia and its RAI staging.		
24. Is the tumor in the presence of HIV infection? Please circle.	Yes	No
If Yes to Question 24, please indicate patient's status of patient's HIV infection and date when he/she was diagnosed with HIV infection:		
25. Please provide details of all investigations / test performed. Please enclose copies of all reports including biopsy, reports, cytology reports, X-rays, CT scans, other imaging studies, laboratory evidence, surgical reports, etc. and any relevant hospital reports that are available.		

Part II

26. Did the patient undergo any surgery? Please circle. If Yes, please provide the following details and a copy of the operation report.	Yes	No

Date of surgery (dd/mm/yy)	Name of surgery	Was surgery performed for total or partial organ removal?	Reason for performing the surgery.

27. If mastectomy was performed due to a diagnosis of invasive breast cancer, please state if reconstructive surgery was done? Please circle.	Yes	No

If Yes, please state date of breast reconstructive surgery. (dd/mm/yy)	If No and patient was recommended for reconstructive surgery, please state date of planned surgery. (dd/mm/yy)

28. Did the patient undergo any other type of non-surgical treatment option? (e.g. chemotherapy, radiotherapy, etc.) Please circle. If Yes, please provide the following details.	Yes	No

Date of treatment (dd/mm/yy)	Type of treatment	Patient's response to treatment

Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**	Date

29. Has any treatment and therapy now been rejected in favor of relief of symptoms? Please circle.	Yes	No
If Yes to Question 29, please provide reasons why treatment and therapy has been rejected:		
30. Does patient's condition require a major organ or bone marrow transplant? Please circle. If Yes, please provide the following details:	Yes	No
a. For major organ transplant, was the transplant resulted from an irreversible end stage failure of the relevant organ? Please circle.	Yes	No

Which organ is involved?	**Date of transplantation** (dd/mm/yy)	**Prognosis of patient's condition**

b. For bone marrow transplant, is the receipt of transplant from human bone marrow using haematopoietic stem cells preceded by total bone marrow ablation? Please circle.	Yes	No
Part III		
31. Has the patient's condition resulted in him/her to be physically or mentally disabled from ever continuing in any employment? If Yes, please state:	Yes	No
a. What were the patient's main physical or mental impairment and the severity of these limitations?		
b. What is your reason that the patient is incapable of any employment throughout his/her lifetime?		
c. In accordance to the Singapore's Mental Capacity Act (Cap 177A), is the patient mentally incapacitated? Please circle.	Yes	No
32. In your opinion, is patient's condition highly likely to lead to death within the next 12 months? Please circle.	Yes	No
If Yes to Question 32, what is your reason of your evaluation?		
33. Please circle your reply to Question (a) to (d) below, if patient's condition or surgery performed in any way related to or due to:-		
a. AIDS, AIDS-related complex or infection by HIV?	Yes	No
b. Drug abuse or use of drug not prescribed by registered medical practitioner	Yes	No
c. Alcohol abuse or misuse?	Yes	No

Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**	Date

d. Congenital anomaly or defect?	Yes	No

If Yes to any of Question 33(a) to (d), please provide the following in detail and to provide a copy of the investigation test result:

Exact diagnosis	Date of diagnosis (dd/mm/yy)	Name and address of treating doctor

34. Has the patient previously suffered from cancer, tumor, cyst or growth of any kind, or enlarged nodes? If Yes, please provide the following details:	Yes	No

Diagnosis	Date of diagnosis (dd/mm/yy)	Date when patient was informed of diagnosis	Name and date of treatments	Name and address of treating doctor

35. Is there anything in patient's medical history which would have increased the risk of having cancers? If Yes, please provide the following details:	Yes	No

Diagnosis	Date of diagnosis (dd/mm/yy)	Date when patient was informed of diagnosis	Name and date of treatments	Name and address of treating doctor

36. Does the patient have or ever had any other significant medical condition? Please circle. If Yes, please provide the following details:	Yes	No

Diagnosis	Date of diagnosis (dd/mm/yy)	Date when patient was informed of diagnosis	Name and date of treatments	Name and address of treating doctor

Name and Signature of the Medical Specialist who filled up **Section 2**	Date
Practice Stamp of the Medical Specialist	

SECTION 3
Attachment of Laboratory Reports

To enable us to proceed with the claim, it is mandatory to enclose all relevant clinical, radiological, histological, operation and laboratory reports by attaching them to this page.

1. Histopathological / Biopsy reports
2. Operation reports (if surgery has been performed)

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