Claimant Statement

DAILY HOSPITAL INCOME, SURGICAL EXPENSE BENEFIT, ACCIDENTAL MEDICAL EXPENSE REIMBURSEMENT

PRU LIFE U.K.

We're very sorry about your condition. We know this is important to you, so let us help you with this claim.

Instructions:

1. Completely and clearly fill out this form if you are the Life Insured.
2. Put "N/A" if not applicable. Do not sign a blank form.
3. Submit the accomplished form with the complete requirements via the email address below.

Please expect an update on the status of your claim through your mobile number and/or email address. If you have further questions or concerns, please feel free to contact us.

contactclaims@prulifeuk.com.ph | (+632) 8884 8484 within Metro Manila, 1 800 10 PRULINK for domestic toll-free | www.prulifeuk.com.ph

REQUIREMENTS

STANDARD REQUIREMENTS

- ☐ Hospitalization and Reimbursement Claim form
  This form should be signed by the Policyowner. Claim proceeds will be paid to the Policyowner.
- ☐ One (1) valid government-issued photo ID of the Life Insured
- ☐ Attending Physician's Statement
  This must be duly accomplished by the physicians who attended to the Life Insured.

ADDITIONAL MANDATORY REQUIREMENTS BASED ON TYPE OF CLAIM

Daily Hospital Income/Intensive Care Unit

- ☐ Hospital Statement of Account with admission and discharge date

Surgical Expense Benefit

- ☐ Record of Operation
- ☐ Official Receipts related to the surgery or procedure

Accidental Medical Reimbursement Benefit

- ☐ Official Receipts related to the treatment of the injury
- ☐ Prescription of the medicines used during treatment

Please see our website https://www.prulifeuk.com.ph for other conditional requirements that may need to be submitted.

INSURED INFORMATION

POLICY NUMBER/S

FULL NAME (last, first, middle)

DATE OF BIRTH (mm/dd/yyyy)

LATEST HOME ADDRESS (unit, building, number, street, subdivision, barangay, city, province)

ZIP CODE

HEALTH HISTORY

Fully describe the extent and nature of the Life Insured's illness

When did the Life Insured first consult a medical practitioner in connection with their illness?

What symptoms did Life Insured experience which resulted in their hospitalization/consultation?

When did the symptoms begin?

Has the Life Insured previously suffered or received any treatment for a similar or related illness?

☐ Yes ☐ No If yes, please give details

WARNING: FILING OF FRAUDULENT CLAIMS IS PENALIZED BY LAW.

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.

HEALTH HISTORY

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

DATE (MM/DD/YYYY)	HOSPITAL / CLINIC	PHYSICIAN	DIAGNOSIS	TREATMENT

Provide details of Doctors or Specialist the Life Insured has consulted in connection with their illness on the space provided below. (Please use a separate sheet if needed)

DATE (MM/DD/YYYY)	NAME	ADDRESS	FINDINGS	DURATION OF CONFINEMENT/CONSULTATION

HOSPITALIZATION DETAILS

DATE OF ADMISSION/ CONSULTATION (mm/dd/yyyy)

DATE OF DISCHARGE (mm/dd/yyyy)

NUMBER OF DAYS OF CONFINEMENT

FINAL DIAGNOSIS

FOR INTENSIVE CARE UNIT BENEFIT (Fill out only if applicable; otherwise, put N/A)

DATE OF ADMISSION (mm/dd/yyyy)

DATE OF DISCHARGE (mm/dd/yyyy)

REASON FOR ADMISSION

NUMBER OF DAYS

DOCTOR IN CHARGE

FOR SURGICAL EXPENSE BENEFIT (Fill out only if applicable; otherwise, put N/A)

DATE OF OPERATION (mm/dd/yyyy)

TYPE OF OPERATION

POST-OPERATION DIAGNOSIS

NAME OF SURGEON

NAME OF ANESTHESIOLOGIST

FOR ACCIDENTAL BENEFIT (Fill out only if applicable; otherwise, put N/A)

DATE AND TIME OF ACCIDENT (mm/dd/yyyy)

PLACE OF ACCIDENT

CAUSE OF ACCIDENT/INJURY

EXTENT OF INJURY

Was the Life Insured at work/official business when the accident injury happened? ☐ Yes ☐ No

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

RECEIPT SUMMARY (Fill out only if applicable; otherwise, put N/A)

Please use a separate sheet if necessary.

DATE (MM/DD/YYYY)	OFFICIAL RECEIPT NO.	PARTICULARS	AMOUNT

PAYOUT DETAILS (should be the Policyowner's details for policies where the Life Insured is different from the Policyowner)

☐ **FUND TRANSFER**

BANK NAME _____ CURRENCY ☐ PHP ☐ USD

ACCOUNT NAME _____ ACCOUNT NUMBER _____

Note: Fund transfer to PESONet participating banks is free of charge. Fund transfer to Dollar bank accounts using non-accredited banks is subject to bank charges. For Philippine peso pay-outs, please elect a Philippine peso account. For US dollar pay-outs, please elect a US dollar account. If claim proceeds are more than PHP 1,000,000 or USD 20,000, please provide proof of ownership of the bank account (eg. Photocopy or picture of bank account passbook, deposit slip, or statement of account)

☐ **GCASH (UP TO PHP 50,000 ONLY)** MOBILE NUMBER _____

Note: Gcash account should be fully verified.

☐ **CHECK PICK-UP** PREFERRED CUSTOMER CENTER _____

Note: We only allow check issuance for beneficiaries with no bank account or no GCash account. Please expect an additional 5-10 calendar days for check availability.

If a representative is designated to claim the cheque, the following must be presented: (a) authorization letter and (b) valid government-issued photo ID of the representative.

PURPOSE STATEMENT

We will use the information you have provided in this form to process 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

DECLARATION AND SIGNATURE

I am making a claim on the insurance of the Life Insured (who may also be referred to as the Life Assured) with Pru Life Insurance Corporation of U.K. ("Pru Life UK") and agree that the written statements and affidavits of the physicians who attended to or treated the Life Insured and all other supporting documents required for the claim, shall constitute and be considered as proof of the medical condition of the Life Insured. I understand and agree that Pru Life UK furnishing me with this Claimant Statement form (and any other supplemental form) is not an admission by Pru Life UK that there was any insurance in force on the Life Insured or of liability for payment of any benefit provided in any insurance policy issued by Pru Life UK, and is not a waiver of any of its rights or defenses.

By selecting the mode of payout and providing the account information where proceeds will be released, and in consideration of any payment received from Pru Life UK in relation to this claim, I completely release, discharge, and hold free and harmless Pru Life UK and any of its affiliates, directors, officers, employees and successors-in-interest ("Related Parties") 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 warrant that this declaration may be pleaded as an absolute bar to any litigation or suit in connection with this claim. In case Pru Life UK becomes a party to any such litigation or suit, I agree to defend Pru Life UK and any Related Parties and to fully answer all costs and expenses to which Pru Life UK may be entitled, including attorney's fees, interests, penalties and other damages arising from such litigation or suit.

All information given by me in this Claimant Statement is correct, true and complete.

✓ **Signature over printed name of the Policyowner**
(if different from the Life Insured)

PLACE OF SIGNING

DATE OF SIGNING (mm/dd/yyyy)

✓ **Signature over printed name of the Life Insured**

PLACE OF SIGNING

DATE OF SIGNING (mm/dd/yyyy)

AUTHORIZATION LETTER

This is to authorize Pru Life UK, and _____, the authorized third-party provider of Pru Life UK ["Third-Party Provider"] and/or their duly authorized representatives to secure any and all information or records in relation to the Life 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 on the life of the Life Insured, for which I have submitted this Claimant Statement form.

It is understood that by virtue of this authorization, any 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 the records or information in connection with the Life Insured.

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

✓ **Signature over printed name of the Life Insured**

PLACE OF SIGNING

DATE OF SIGNING (mm/dd/yyyy)