AIA

CONFIDENTIAL MEDICAL CERTIFICATE－醫生報告

PART II - To be completed by doctor at Insured's / Claimant's expense 第二部份（受保人或申請人自費由主診醫生填寫)

Policy Number 保單號碼	
Name of Insured 受保人姓名	ID Card / Passport No. 身分證 / 護照號碼

CRITICAL ILLNESS－CROHN'S DISEASE
危疾－克羅恩氏病

GENERAL INFORMATION －般資料

1. Are you the Insured's usual medical physician?
閣下是否受保人慣常求診之醫生？ ☐ Yes 是 ☐ No 否

   If "yes", when did the Insured first consult you? 如"是"，請問受保人首次向閣下求診之日期？

   ☐☐ ☐☐ ☐☐☐☐
   MM月 DD日 YYYY年

2. When were you first consulted for this illness?
受保人首次就有關疾病向閣下求診之日期。

   ☐☐ ☐☐ ☐☐☐☐
   MM月 DD日 YYYY年

   What were the symptoms? 受保人之病徵。

   _____

   How long had the symptoms been present? 該病徵約存在了多久?

   _____

3. Has the Insured previously suffered from this illness or any related conditions?
受保人是否有同類之病史？ ☐ Yes 是 ☐ No 否

   If "yes", please give dates of consultations and the resulting diagnosis. 如" 有"，請提供求診日期及診斷詳細結果。

   _____

4. On which date was the diagnosis made? 有關疾病之診斷是何時首次確認？

   ☐☐ ☐☐ ☐☐☐☐
   MM月 DD日 YYYY年

   On which date was the Insured first made aware of it? 受保人何時首次知悉有關疾病之診斷？

   ☐☐ ☐☐ ☐☐☐☐
   MM月 DD日 YYYY年

5. Is there anything in the Insured's family history which would have increased the risk of this illness?
受保人之家族病史是否增加受保人患上此病之機會？ ☐ Yes 是 ☐ No 否

6. Is the Insured a smoker? 受保人是否吸煙人仕？ ☐ Yes 是 ☐ No 否

   If "Yes", what is his / her smoking habit? 若為吸煙人仕，他 / 她的吸煙習慣為何？
   Daily smoking amount 每日吸煙數量：_____ for how many years? 吸食年數：_____

7. Other physicians or medical facilities the patient has consulted for this condition.
受保人曾經就診之其他醫生或醫療機構資料。

Name of physician / facility 醫生 / 機構名稱	Address 地址	Date of consultation / confinement period 求診日期 / 住院時段

Details of "Yes" answers (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities).
如答"是"，請提供診斷結果、日期、病徵持續時期及主診醫生姓名、醫療機構名稱及地址等資料。

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DETAILS OF THE INSURED'S ILLNESS 受保人病況之詳情

8. Please provide full and exact details of the diagnosis. 請提供受保人之所有及確定的診斷詳情。

9. Please describe the extent of the disease. 請描述該疾病之狀況。

i. Was there any evidence of continued inflammation of the bowel in spite of optimal therapy?
是否有證據證明即使病人接受最佳治療後大腸及小腸仍然持續發炎？ ☐ Yes 是 ☐ No 否

ii. Was there any stricture formation?
是否出現腸道狹窄？ ☐ Yes 是 ☐ No 否

iii. Was there any intestinal obstruction?
是否出現腸阻塞？ ☐ Yes 是 ☐ No 否

iv. Was admission to hospital required?
是否需住院治療？ ☐ Yes 是 ☐ No 否

If yes, please state the period(s) of hospital confinement(s). 如有，請列出住院時段。

Date of Admission 入院日期 Date of Discharge 出院日期

From 由 ☐☐ ☐☐ ☐☐☐☐ MM月 DD日 YYYY年 To 至 ☐☐ ☐☐ ☐☐☐☐ MM月 DD日 YYYY年

Name of Hospital
醫院名稱：_____

Name of Attending doctor
主診醫生名稱：_____

v.. Was there any fistula formation between loops of bowel?
是否出現腸道瘻管現象？ ☐ Yes 是 ☐ No 否

vi.. Was there any bowel resection done?
病人是否接受腸道切除手術？ ☐ Yes 是 ☐ No 否

If yes, please specify the area(s) of resection.
如有，請説明切除之部分。

_____

_____

10. i. Was the diagnosis confirmed by a gastroenterologist?
此疾病是否經腸胃科專科醫生確診？ ☐ Yes 是 ☐ No 否

Please give name and address of the gastroenterologist confirming the diagnosis if it is not the undersigned.
若非由填寫此表格之醫生確診，請提供確診之腸胃科專科醫生之姓名及地址。

_____

_____

ii. Was the diagnosis proven histologically in a pathology report?
是否經組織病理學報告確實診斷？ ☐ Yes 是 ☐ No 否

iii. Was the diagnosis proven in the results of sigmoidoscopy or colonoscopy?
是否經直腸或大腸鏡檢查確實診斷？ ☐ Yes 是 ☐ No 否

If yes, please provide the pathology report and / or the results of sigmoidoscopy or colonoscopy.
如是，請提供組織病理學報告及 / 或直腸或大腸鏡檢查報告。

11. Please enclose copies of all reports including all reports, radiological procedures, MRI, CT scanning, electroencephalography, biopsy, laboratory evidence, other imaging studies, etc. and any relevant hospital reports that are available.
請提供所有報告，如放射性治療、磁力共振、電腦掃描、腦電圖、活體檢驗記錄、化驗報告及其他影像報告等，或任何有關的醫院報告。

12. Please state if the Insured has suffered / been treated for any other major illness(es) in the past. 請列明受保人曾患上或接受治療的其他主要疾病。

13. Is there any further information, which in your opinion will assist us in assessing this claim? 請提供其他有助審核本索償個案之資料。

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該聲明的符合相關守則及法規之最新版本可於以上網址下載及可供索取。

Name of doctor and qualification 醫生姓名及醫學資格

Signature and official chop 簽署及蓋印

Address and telephone number 地址及聯絡電話

Date 日期

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