

**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 <div></div>	
Name of Insured 受保人姓名 <div></div>	ID Card / Passport No. 身分證 / 護照號碼 <div></div>

**CRITICAL ILLNESS – SEVERE ULCERATIVE COLITIS****危疾 – 嚴重潰瘍性結腸炎****GENERAL INFORMATION 一般資料**

<p>1. Are you the Insured's usual medical physician? 閣下是否受保人慣常求診之醫生？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>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？ <div><div></div><div></div><div></div><div></div><div></div><div></div></div> MM月 DD日 YYYY年</p>	<p>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。</p>											
<p>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。 <div><div></div><div></div><div></div><div></div><div></div><div></div></div> MM月 DD日 YYYY年</p> <p>What were the symptoms? 受保人之病徵。  <div></div> How long had the symptoms been present? 該病徵約存在了多久？ <div></div></p>												
<p>3. Has the Insured previously suffered from this illness or any related conditions? 受保人是否有同類之病史？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>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。 <div></div></p>												
<p>4. On which date was the diagnosis made? 有關疾病之診斷是何時首次確認？ <div><div></div><div></div><div></div><div></div><div></div><div></div></div> MM月 DD日 YYYY年</p> <p>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？ <div><div></div><div></div><div></div><div></div><div></div><div></div></div> MM月 DD日 YYYY年</p>												
<p>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？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p>												
<p>6. Is the Insured a smoker? 受保人是否吸煙人仕？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>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：_____</p>												
<p>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。</p> <table border="1"><thead><tr><th>Name of physician / facility 醫生 / 機構名稱</th><th>Address 地址</th><th>Date of consultation / confinement period 求診日期 / 住院時段</th></tr></thead><tbody><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr></tbody></table>		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								
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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 acute fulminant life threatening electrolyte disturbances?

是否出現急性爆發性並導致威脅生命的電解物質異常？

☐ Yes 是

☐ No 否

If "yes", please provide the detail.

如“是”，請提供詳細情況。

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ii. Was the entire colon affected?

是否整條大腸受影響？

☐ Yes 是

☐ No 否

Was there any bloody diarrhoea?

是否出現帶血腹瀉？

☐ Yes 是

☐ No 否

iv. Was total colectomy and ileostomy done?

是否曾接受完全大腸切除及迴腸造口術？

☐ Yes 是

☐ No 否

10. 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。

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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。

I / We hereby declare that the information given on this form is true and complete to the best of my / our knowledge and belief.  
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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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