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）

SERIOUS INFECTIOUS DISEASE 嚴重傳染病

Policy Number 保單號碼

Name of Insured 受保人姓名

ID Card / Passport No. 身份證 / 護照號碼

GENERAL INFORMATION 一般資料

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? 受保人是否吸煙人士？

   ☐ Yes 是 ☐ No 否

   If "Yes", what is his / her smoking habit? 若為吸煙人士，他 / 她 的吸煙習慣如何？

   Daily smoking amount 每日吸煙數量：_____ for how many years? 吸食年數：_____

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。

OTHER / ADDITIONAL INFORMATION 其他 / 附加資料

1. Please provide names, addresses and dates of doctors and hospitals which the Insured was referred and / or admitted to.
   請提供受保人曾經就診之所有醫生姓名或醫院名稱及地址。

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

1. Please provide full and exact details of the diagnosis. 請提供該疾病之狀況及其診斷結果。

_____

_____

2. Is it a disease which is classified as a Public Health Emergency of International Concern by the World Health Organization (WHO)? 該疾病是否被世界衛生組織評定為國際關注的突發公共衛生緊急事件之疾病？

☐ Yes 是 ☐ No 否

3. How was the diagnosis confirmed? (Please state the details of diagnostic test / examination and its result if any) 如何確診該疾病？（請提供相關診斷測試 / 檢查詳情及結果（如適用））

_____

_____

4. Was there any admission in Intensive Care Unit? 受保人是否曾入住深切治療部? ☐ Yes 是 ☐ No 否
If yes, please provide the below details. 如是，請提供以下詳情。

Hospital Name 醫院名稱	Period in Intensive Care Unit 入住深切治療部日期	
	From 由	To 至

5. Please enclose copies of all reports including X-rays, CT scans, ultrasound or other imaging studies, ECGs, surgical reports, laboratory evidence. Etc. and any relevant hospital reports that are available.
請提供所有報告包括X光檢查、電腦掃描、超聲波及其他影像報告、心電圖、手術報告及化驗報告等，或任何有關的醫院報告。

6. 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。

_____

_____

7. 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。

_____

_____

保單號碼 | | | | | | | | | | |

I / We hereby declare that the information given on this form is true and complete to the best of my / our knowledge and belief.
本人 / 我們現聲明此申請書上所填資料皆為本人 / 我們所知及所信之事實及其全部。

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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 MM月 DD日 YYYY年

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