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）

SEVERITY-BASED HEALTH PROTECTION 嚴重程度健康保障

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。

保單號碼 | | | | | | | | | | |

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

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

_____

_____

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) 受保人是如何被確診？（請提供相關診斷測試 / 檢查詳情及結果（如適用））

_____

_____

PLEASE PROVIDE FURTHER DETAILS IF THE DIAGNOSIS IS CANCER / CARCINOMA-IN-SITU
如診斷結果為癌症 / 原位癌，請提供進一步資料

1. Is the diagnosis confirmed with histological examination? 診斷是否經病理分析確定？

   If yes, please provide the type and date of histological examination performed. 如是，請提供所作病理分析之類別及進行日期。

_____

_____

MM月		DD日		YYYY年			

2. If histological examination is not done, what is the reason? 若未有進行病理分析，原因為何？

_____

3. Histological result 病理分析結果

   i. Is the histological result carcinoma-in-situ? 病理分析結果是否原位癌？

   ☐ Yes 是 ☐ No 否

   ii. Is there uncontrolled growth of malignant cells? 癌細胞是否不受控制地生長？

   ☐ Yes 是 ☐ No 否

   iii. Is there any clear stromal invasion of malignant cells? 癌細胞是否有明顯入侵基質?

   ☐ Yes 是 ☐ No 否

   iv. What is the staging of the cancer according to the TNM classification system? (For Chronic Lymphocytic Leukemia, please state the RAI Stage.) 根據TNM 評級系統， 此癌症屬於哪一階段？（慢性淋巴性白血病，則請列出其RAI級別。）

_____

   v. Is there any distant metastasis? If yes, any identified secondary site? 癌細胞有否擴散至其他器官？如有，已確認被擴散的器官？

   ☐ Yes 有 ☐ No 沒有

_____

4. Was the diagnosis confirmed by specialists? 此疾病是否經專科醫生確診？

   Please give name, address and specialty of the specialist confirming the diagnosis if it is not the undersigned.
   若非由填寫此表格之醫生確診，請提供確診之專科醫生之姓名，地址及專科。

_____

_____

PLEASE PROVIDE FURTHER DETAILS IF THE DIAGNOSIS IS HEART ATTACK
如診斷結果為心臟病，請提供進一步資料

1. Please describe the attack? 請描述有關之病況。

   i. Date of Attack. 病發日期 MM月 DD日 YYYY年

   ii. Was it a case of angina? 該個案是否心絞痛? ☐ Yes 是 ☐ No 否

   iii. Was there a history of typical chest pain? 有否典型的胸痛病歷？ ☐ Yes 有 ☐ No 沒有

   If yes, please give details of the history. 如有，請提供病歷之詳情。

   _____

   iv. Was there death of a portion of heart muscle resulted? 有否引致心臟肌肉壞死? ☐ Yes 有 ☐ No 沒有

   If yes, was it caused by surgical or invasive procedure to the heart or the coronary arteries? Or, other causes? Please specify. 如有，心臟肌肉壞死是否因對心臟或冠狀動脈進行任何創傷性或手術程序導致? 或其他原因導致? 請列明。

   _____

   v. Was there elevation of cardiac enzymes or Troponin? 心肌酵素或心肌旋轉蛋白有否升高？ ☐ Yes 有 ☐ No 沒有

   If yes, please give details of the date and the result. If serial tests have been done, please list all the results.
   如有，請提供有關之化驗日期及結果。若進行了連串的化驗，請列出所有的結果。

Date (MM / DD / YY) 日期（月 / 日 / 年）	Test done 所作之化驗	Result 結果

   vi. (a) Were there new characteristic ECG changes indicating acute myocardial infarction at the time of the relevant cardiac incident?
   在相關心臟事故期間心電圖有否顯示新近具急性心肌梗塞特徵的變化？ ☐ Yes 有 ☐ No 沒有

   (b) Were there new ECG changes indicating insufficient blood supply to the heart muscle at the time of the relevant cardiac incident?
   在相關心臟事故期間心電圖有否新的改變顯示心臟肌肉血液供應不足？ ☐ Yes 有 ☐ No 沒有

   (c) If any of the above is “yes”, please give details of the changes. 如以上任何答案為“有”，請提供有關變化之詳情。

   _____

   _____

PLEASE PROVIDE FURTHER DETAILS IF THE DIAGNOSIS IS HEART FAILURE
如診斷結果為心臟衰竭，請提供進一步資料

1. Is there any permanent physical impairment as a result of the impaired function of the heart? 是否因心肌功能受損導致永久性損害?

   ☐ Yes 是 ☐ No 否

   If yes, please describe the physical impairment and how long has the condition been medically documented?
   如“是”，請形容功能受損之情況及持續了多久？

   _____

   _____

2. What would you rank the degree of such impairment according to the New York Heart Association classification? 根據美國紐約心臟病學會之心臟功能分級，受保人之情況是屬於何等級?

   ☐ Class I (Mild) 第一級（輕微程度）
   ☐ Class II (Mild) 第二級（輕微程度）
   ☐ Class III (Moderate) 第三級（中等程度）
   ☐ Class IV (Severe) 第四級（嚴重程度）

3. Is such impairment diagnosed by cardiologist? 受保人之情況是否經心臟專科醫生確診?

   ☐ Yes 是 ☐ No 否

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

   _____

   _____

PLEASE PROVIDE FURTHER DETAILS IF THE DIAGNOSIS IS STROKE
如診斷結果為中風，請提供進一步資料

1 If the diagnosis is Stroke, 若診斷為中風,
   (a) is it based on changes seen in a CT or MRI? 是否基於 CT 或 MRI 顯示之轉變? ☐ Yes 是 ☐ No 否
   (b) is it confirmed by a neurologist? 是否經腦神經專科醫生確診? ☐ Yes 是 ☐ No 否
   (c) Please give name and address of the neurologist confirming the diagnosis if it is not the undersigned.
   若非由填寫此表格之醫生確診，請提供確診之專科醫生之姓名及地址。

_____

2. The exact cause of the incident (e.g. infarction of brain tissue, haemorrhage cerebral embolism, etc.) 事故之因由（如因腦組織梗塞、腦出血、血栓等原因引致）。

_____

Is the cerebral symptoms due to the following? 腦部症狀是否因下列引致?
   i. transient ischaemic attacks? 短暫性腦缺血? ☐ Yes 是 ☐ No 否
   ii. migraine? 偏頭痛? ☐ Yes 是 ☐ No 否
   iii. vascular disease affecting the eye or optic nerve or vestibular functions? ☐ Yes 是 ☐ No 否
   眼或視神經或前庭系統功能造成影響的血管疾病?

3. Details of diagnostic procedures performed and the results (e.g. MRI, CT Scan, Angiography, etc.) 診斷詳情及結果（如磁力共振、電腦掃描、血管造影術等）。

_____.

4. Is there any neurological sequelae resulted from the stroke? 是次中風有沒有引發神經後遺症？ ☐ Yes 有 ☐ No 沒有
   If "yes", please state the details of neurological sequelae: 如"有"，請提供有關神經後遺症之詳情：

_____

_____

How long has the neurological sequelae lasted from the date of onset? 有關之神經後遺症由病發起持續了多久？

_____

Please provide your professional comment on whether such neurological sequelae is reversible or going to result in permanent neurological deficits? 請評估上述的神經後遺症是否可復原或會成為永久性的神經機能缺損？

_____

PLEASE PROVIDE FURTHER DETAILS IF THE DIAGNOSIS IS LIVER FAILURE
如診斷結果為肝衰竭，請提供進一步資料

1 Details for Liver Failure 肝衰竭之詳情：
   i. Is there any end stage liver failure? 該病之徵狀是否屬於末期肝功能衰竭？ ☐ Yes 是 ☐ No 否
   If yes, 如"是"，
      a. Is there any permanent jaundice? 有沒有持續性黃疸？ ☐ Yes 有 ☐ No 沒有
      b. Is there any ascites? 有沒有腹水現象？ ☐ Yes 有 ☐ No 沒有
      c. Is there any hepatic encephalpoathy? 有沒有肝性腦病？ ☐ Yes 有 ☐ No 沒有
   ii. Is the liver disease / disorder caused by alcohol and / or drug abuse? If yes, please give details.
   肝臟疾病 / 紊亂是否因酒精及 / 或濫用藥物引致？如"是"，請提供詳情。 ☐ Yes 是 ☐ No 否

_____

_____

PLEASE PROVIDE FURTHER DETAILS IF THE DIAGNOSIS IS KIDNEY FAILURE
如診斷結果為腎衰竭，請提供進一步資料

1. Diagnosis date of Kidney Failure
   腎功能之診斷日期： | | MM月 | | DD日 | | | | YYYY年

2. Are both kidney involved and chronically irreversible from End-stage Kidney Failure?
   是否兩個腎臟都受牽連及情況已到不可逆轉的末期衰竭? ☐ Yes 是 ☐ No 否

3. Is the Insured undergoing regular peritoneal dialysis or haemodialysis?
   受保人是否需要進行定期腹膜或血液透析? ☐ Yes 是 ☐ No 否
   If yes, start date 如是，開始接受治療日期： | | MM月 | | DD日 | | | | YYYY年

4. Has renal transplantation been performed? 有否接受腎臟移植手術? ☐ Yes 是 ☐ No 否
   If yes, start date 如是，接受日期： | | MM月 | | DD日 | | | | YYYY年

PLEASE PROVIDE FURTHER DETAILS IF THE DIAGNOSIS IS LUNG FUNCTION FAILURE
如診斷結果為肺功能衰竭，請提供進一步資料

1. What is the FEV 1 test result of the Insured during the first second of a forced exhalation? 受保人在用力呼氣的第一秒期間的FEV1測驗結果如何？

_____

2. What is the baseline arterial blood gas analysis result? 受保人的基準動脈血氧分析結果如何？

_____

3. Does the insured feel dyspnea at rest? 受保人於靜止時是否會感覺呼吸困難？
   ☐ Yes 是 ☐ No 否
4. Does the Insured require oxygen therapy? 受保人是否需要接受氧氣治療？
   ☐ Insured requires extensive & permanent oxygen therapy. 受保人需要廣泛及永久接受氧氣療法。
   ☐ Insured only requires intermittent oxygen therapy. 受保人只需要間歇性接受氧氣治療。
   ☐ Insured does not require oxygen therapy. 受保人不需要接受氧氣治療。

   If insured is currently under oxygen therapy, please give details such as start date, flow rate, concentration and frequency. 如受保人現正接受氧氣治療，請提供詳情（如：開始日期、流速、濃度及使用次數。）

   Start Date of Oxygen Therapy 開始接受氧氣治療之日期： | | | | | | | | | |
   MM月 DD日 YYYY年

   Flow Rate 流速：_____

   Concentration 濃度：_____

   Frequency 每月使用次數：_____

SEVERITY FACTOR－SURGERY 嚴重程度因素－手術

Was there any surgery performed? 受保人是否曾接受手術？ ☐ Yes 是 ☐ No 否
If yes, please provide the below details. 如是，請提供以下詳情。

1. Please provide the name, details and date of surgical procedure(s). 請提供手術名稱，詳情及日期。 | | | | | | | | | |
   MM月 DD日 YYYY年

_____

2. Has the Insured already undergone organ transplantation or is Insured on organ transplant waiting list? 受保人是否已接受器官移植手術或於主要器官移植之候補名單上？

   ☐ Yes 是 ☐ No 否

   If yes, please provide the details. If no, please skip to next Severity Factor. 如是，請提供詳情。如否，請繼續填寫下一個嚴重程度因素。

   a. Has the Insured already undergone organ transplantation? 受保人是否已接受器官移植手術？

      ☐ Yes 是
      i. Date of transplant 進行移植手術之日期：
      ii. Place where the transplant was done 進行器官移植的地方： | | | | | | | | | |
      MM月 DD日 YYYY年

      _____

      ☐ No, Insured is on the Hong Kong Hospital Authority official organ transplant waiting list or the government-regulated official organ transplant waiting list in his / her residential country. 否，受保人於香港醫院管理局或其居住國家政府所監管的官方正式器官移植輪候冊名單上輪候移植。

      i Expected date of the transplant 預期進行移植手術之日期： | | | | | | | | | |
      MM月 DD日 YYYY年

      ☐ Others (please specify) 其他（請註明）

      _____

   b. What kind of organ transplant has the Insured undergone / been waiting to undergo as a recipient?
      受保人已接受了 / 正在輪候接受下列哪種器官移植？

      ☐ Transplant of Human Organ 人體器官移植 (Name of organ involved 接受移植之器官：_____)

      ☐ Transplant of Human Bone Marrow 人體骨髓移植

      i. Is bone marrow transplant preceded by total bone marrow ablation?
         人體骨髓移植前是否會先進行全身骨髓消融？

         ☐ Yes 是 ☐ No 否

      ☐ Others (please specify) 其他（請註明）

      _____

   c. What cause the need for the organ transplant? 需要接受器官移植之原因。

      _____

   d. Was the diagnosis confirmed by two specialists? 此疾病是否經兩個專科醫生確診？
      Please give name, address and specialty of the specialist confirming the diagnosis if it is not the undersigned.
      若非由填寫此表格之醫生確診，請提供確診之專科醫生之姓名，地址及專科。

      _____

      _____

      Please enclose copies of reports from the specialists and all clinical and / or pathological evidence supporting such transplantation is provided. 請提供所有專科醫生診斷報告及醫療或 / 及病理報告證明已 / 將進行器官移植。

SEVERITY FACTOR－TREATMENT 嚴重程度因素－治療

Has insured undergone any treatment / therapy / medication ? 受保人是否曾接受治療 / 藥物治療？ ☐ Yes 是 ☐ No 否

If yes, please provide the below details. 如是，請提供以下詳情。

1.

Name of Treatment / Therapy / Medication 治療 / 藥物治療名稱	Frequency / Dosage 次數 / 劑量	Period of Treatment 治療日期	
		From 由	To 至

SEVERITY FACTOR－SEVERE HOSPITAL STAY 嚴重程度因素－嚴重住院

Was there any confinement? 受保人是否曾住院？ ☐ Yes 是 ☐ No 否

If yes, please provide the below details.如是，請提供以下詳情。

1.

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

2. Was the Insured suffer from Coma during the confinement? If yes, please give the below details. 受保人曾在住院期間昏迷？如是，請提供詳情。

☐ Yes 是 ☐ No 否

a. Is there any reaction or response to external stimuli? 對外來刺激有沒有反應？

☐ Yes 有 ☐ No 沒有

If no response, how long has it persisted? 如沒有反應，持續了多久？

_____

b. Is there any reaction or response to internal needs? 對體內需求有沒有反應？

☐ Yes 有 ☐ No 沒有

If no response, how long has it persisted? 如沒有反應，持續了多久？

_____

c. Is there any permanent neurological defect? 有沒有永久性的神經機能缺損？

☐ Yes 有 ☐ No 沒有

d. How long is it expected that the Insured will remain in coma? 請估計受保人之昏迷狀態會維持多久。

_____

e. What was the cause of the coma? 昏迷是因何引致？

_____

f. Was the coma directly resulted from self-inflicted injury? 是否直接因自致的傷害引致？

☐ Yes 是 ☐ No 否

g. Was the coma directly resulted from alcohol or drug abuse? 是否直接因酒精或濫用藥物引致？

☐ Yes 是 ☐ No 否

Severity Factor－Disability 嚴重程度因素－殘廢

(Not applicable to AIA One Absolute– Cancer & Serious Infectious Disease Protection / AIA One Absolute Pearl – Cancer & Serious Infectious Disease Protection 不適用於AIA唯一摯保 - 癌症及嚴重傳染病保障 / AIA唯一摯保明珠 - 癌症及嚴重傳染病保障)

1. Please put a tick ✓ in the box of the following daily activities if the Insured is NOT able to perform. Please provide the start date of disability, the details and whether it is permanent.
   如受保人不能完成下列日常生活活動，請在空格劃上✓號，並提供喪失該活動能力的日期及是否屬於永久性。

Daily Activities 日常生活活動	Start date of disability (mm/dd/yyyy) 喪失活動能力的日期 (月月/日日/年年)	Provide the details on why Insured unable to perform such ADL and the underlying cause of it. 請提供有關該受保人喪失該活動能力的詳細資料及原因	Permanently 永久性
The ability to wash oneself in the bath or shower (including getting in or out of the bath or shower) or wash oneself by any other means. 可以自行在浴缸或淋浴間進行沐浴或淋浴（包括進出浴缸或淋浴間）或使用其他方式洗澡的能力。 ☐ No help is needed 無需協助 ☐ Some help / supervision is needed (e.g. to wash the back, to wash hair) 需要小許協助/監督（例如清洗背部，洗頭） ☐ Needs someone to help most of the time 大部分時間需要協助 ☐ Completely requiring someone to help throughout the entire activity (needs to be washed or bathed entirely by caregiver) 整個活動過程中完全需要另一個人從旁協助（需要由護理人員清洗或沐浴）			☐
The ability to put on and take off all necessary clothing, braces, artificial limbs or other surgical appliances. 可以自行穿著及除掉一切所需衣物、背帶、義肢或其他手術器具的能力。 ☐ No help is needed 無需協助 ☐ Some help / supervision is needed (e.g. to button clothes, to put on trousers) 需要小許協助 / 監督（例如穿衣服, 穿褲子） ☐ Needs someone to help most of the time 大部分時間需要協助 ☐ Completely requiring someone to help throughout the entire activity (needs to be dressed entirely by caregiver) 整個活動過程中完全需要另一個人從旁協助（由護理人員幫助照顧穿著）			☐
The ability to get in and out of a chair, bed or wheelchair 可以自行從一張椅子、床或輪椅起身或坐下的能力。 ☐ No help is needed 無需協助 ☐ Some help / supervision is needed (e.g. to be lifted up from lying position to sitting position from bed) 需要小許協助/監督（例如，從床上躺著的姿勢抬起到坐姿） ☐ Needs someone to help most of the time 大部分時間需要協助 ☐ Completely requiring someone to help throughout the entire activity (needs to be bed-ridden) 整個活動過程中完全需要另一個人從旁協助（需臥床）			☐
The ability to move from room to room on level surfaces. 可以自行在室內的平地上從一間房間移動至另一間房間的能力。 ☐ No help is needed 無需協助 ☐ Some help / supervision is needed (e.g. to be supervised by someone closely in case of fall) 需要小許協助 / 監督（例如，跌倒時需由其他人協助） ☐ Needs someone to help most of the time 大部分時間需要協助 ☐ Completely requiring someone to help throughout the entire activity (needs to be carried) 整個活動過程中完全需要另一個人從旁協助（需由其他人協助移動）			☐
The ability to voluntarily control bladder and bowel functions so as to maintain personal hygiene. 有控制膀胱及大腸功能的自發能力，以保持個人衛生。 ☐ No help is needed 無需協助 ☐ Some help / supervision is needed (e.g. to get on or off the toilet). 需要小許協助 / 監督（例如，上廁所） ☐ Needs someone to help most of the time 大部分時間需要協助 ☐ Completely requiring someone to help throughout the entire activity (e.g. needs to be placed on the toilet and cleaned by caregiver, needs caregiver to manage diapers and/or catheter) 整個活動過程中完全需要另一個人從旁協助（例如，需由護理員移動到廁所並清理，護理員更換尿布或尿道管）			☐
The ability to feed oneself once food has been prepared and made available. 可以自己進食已預備好之食物的能力。 ☐ No help is needed 無需協助 ☐ Some help / supervision is needed 需要小許協助 / 監督 ☐ Needs someone to help most of the time 大部分時間需要協助 ☐ Completely requiring someone to help throughout the entire activity (needs caregiver to feed entirely or is tube-fed) 整個活動過程中完全需要另一個人從旁協助（需由護理員餵飼食物或導管餵食）			☐

2. Does insured suffer from loss of body function? 受保人是否喪失能力？ ☐ Yes 是 ☐ No 否

If yes, please provide the below details. 如是，請提供以下詳情。

a. Which part of body is / are involved? 包括身體那一部分？

☐ Limbs 肢體

Please specify which limb(s) and the location of severance. 請指出被切除的是哪一肢體以及被切除的位置。

_____

☐ Ear(s) 耳朵

Right Ear 右耳：_____ decibels Hearing Loss 分貝聽力損失

Left Ear 左耳：_____ decibels Hearing Loss分貝聽力損失

Was the diagnosis confirmed by an audiometric and sound-threshold test? 是否已進行聽力及聲域測驗確診？

☐ Yes 是 ☐ No 否

* Please provide the hearing test report for reference. 請提供聽力測驗報告以供參考。

☐ Eye(s) 眼睛

i. What is the best corrected visual acuity of both eyes at present?
請指出雙眼在有矯視的情況下之最佳視力。

Left eye 左眼：_____ Right eye 右眼：_____

ii. What is the best corrected visual field of both eyes at present?
請指出受影響的眼睛在有矯視的情況下之最佳視野。

Left eye 左眼：_____ Right eye右眼：_____

b. Was the cause of loss of the above body function directly resulted from self-inflicted injury? 以上能力的喪失是否直接因自致的受傷引致？

☐ Yes 是 ☐ No 否

c. Is the loss total and irreversible? 是否屬於完全及永久性之缺陷？

☐ Yes 是 ☐ No 否

d. Was the loss of body function confirmed by a specialist? 此疾病是否經專科醫生確診？

☐ Yes 是 ☐ No 否

Please give name, address and specialty of the specialist confirming the diagnosis if it is not the undersigned.
若非由填寫此表格之醫生確診，請提供確診之專科醫生之姓名，地址及專科。

_____

_____

保單號碼 | | | | | | | | | | |

ADDITIONAL INFORMATION 附加資料

1. Is HIV Infection present in the insured? 受保人有否感染人體免疫力缺乏病毒 (HIV)？ ☐ Yes 有 ☐ No 沒有
   If yes, is there any complications of current claiming illness associated with HIV Infection? Please specify.
   如是，受保人所患的疾病是否受HIV感染的相關併發症？ 請列明。

   _____

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.
請提供所有手術報告、X光檢查、電腦掃描、超聲波及其他影像報告、心電圖、手術報告報告及化驗報告等，或任何有關的醫院報告。

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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