AIA

CRITICAL ILLNESS－ANGELMAN SYNDROME / ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) / MARBLE BONE DISEASE (OSTEOPETROSIS) / SEVERE EPILEPSY / TOURETTE SYNDROME (JUVENILE DISEASE)

危疾－天使綜合症 / 專注力不足過度活躍症 / 大理石骨病 / 嚴重腦癇症 / 妥瑞症（兒童疾病）

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		O9010017
Name of Insured 受保人姓名	ID Card / Passport No. 身分證 / 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 signs and symptoms? 受保人之徵狀。

   How long had the signs and symptoms been present? 該徵狀約存在了多久?

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 有 ☐ No 沒有

   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. Please provide the final diagnosis details. 請提供最後診斷之詳情。

   i. 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

   ii. Was the diagnosis confirmed by a registered pediatric psychiatrist or a neurologist or a specialist in the relevant field? 該疾病是否由兒童精神專科或腦神經專科或相關疾病的專科醫生確認？

   ☐ Yes 是 Please give the name of the registered specialist if s/he is not the undersigned.
   若非由填寫此表格之醫生確認，請提供確認之專科醫生姓名。

   ☐ No 否 Please give the name and specialty of the physician who confirmed the above diagnosis.
   請提供確認上述診斷之醫生姓名及專科。

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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 Related family history (including relationship and age of family member)
相關家族病史（包括家庭成員的關係和年齡）

_____

☐ No 否

OTHER AND ADDITIONAL INFORMATION 其他 / 附加資料

1. Other physicians or medical facilities the Insured has comsulted for this condition.
受保人曾經因此病而就診之其他醫生姓名或醫院名稱及地址。

醫生 / 醫院名稱	地址	就診日期 / 住院期間（月/日/年）

ANGELMAN SYNDROME 天使綜合症

1. Please advise if the diagnosis is confirmed by genetic testing. If so, please provide copy of report.
請說明該診斷是否根據基因檢測確定，如是，請提供檢測報告副本。

☐ Yes 是 ☐ No 否

2. Please advise if the Insured is suffering from the following and describe details on Insured's behaviour or condition:
請說明受保人之下列情況：

i. Developmental delay manifested by gait and speech requiring physical therapy and speech therapy.
表現於步態及言語之發育遲緩，並需要物理治療和語言治療。

☐ Yes 是 ☐ No 否	Please describe details on Insured's behaviour: 請詳細描述受保人的行為表現：

ii. Intellectual disability manifested by severe deficits in verbal and nonverbal social communication skills causing severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others, requiring behavioural therapy, occupational therapy or special education at a government approved special education institution.
表現於言語及非言語社交溝通技巧嚴重不足之智力障礙，導致功能上嚴重缺陷、在社交互動中作出非常有限度的主動及對其他人的社交友好表示作出最小的回應，並需要行為治療、職業治療或由政府認可的特殊教育機構提供的特殊教育。

☐ Yes 是 ☐ No 否	Please describe details on Insured's behaviour: 請詳細描述受保人的行為表現：

iii. Epilepsy requiring treatment with anticonvulsant drug.
需要抗癲癇藥物治療的癲癇。

☐ Yes 是 ☐ No 否	Please advise dosage: 請提供劑量：

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ATTENTION DEFICIT/HYPERACTIVITY DISORDER (ADHD) 專注力不足 / 過度活躍症

1. Please describe the extent of the disease. 請描述該病之狀況。
   Based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which of the following diagnostic criteria are met? Please provide details for those met.
   根據精神疾病診斷及統計手冊 (DSM-5)，受保人符合以下哪些條件？請提供符合條件的詳情。

A. Inattention, or Hyperactivity and Impulsivity 專注力弱或過度活躍及行為衝動	
☐ Yes 是 ☐ No 否	Please describe details on Insured's behaviour: 請詳細描述受保人的行為表現：
B. Distractibility, hyperactivity, and impulsivity affect the Insured at school and at home 分心、過度活躍及行為衝動對受保人之學校及家庭生活造成影響	
☐ Yes 是 ☐ No 否	Please describe details on Insured's behaviour: 請詳細描述受保人的行為表現：
C. A health check shows that the health or learning issue is not caused by other problems 健康檢查顯示健康或學習問題並不是由其他問題所導致	
☐ Yes 是 ☐ No 否	Please describe details on Insured's health check result: 請詳細描述受保人的健康檢查結果：
D. The Insured is undergoing appropriate therapeutic intervention including but not limited to pharmacological treatment prescribed by the Registered Medical Practitioner 受保人正接受適當的介入治療，包括不限於由主診醫生處方的藥物治療	
☐ Yes 是 ☐ No 否	Please describe details on Insured's therapeutic intervention: 請詳細描述受保人的介入治療：

MARBLE BONE DISEASE (OSTEOPETROSIS) 大理石骨病

1. Please advise if the Insured is suffering from the following and describe details on Insured's condition: 請說明受保人之下列情況：
   i. Does Insured suffer from cranial nerve palsy? 請說明受保人是否患有腦神經麻痺。
   ☐ Yes 是 Please advise details. 請描述其詳細狀況。

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   ☐ No 否

   ii. Does Insured suffer from pancytopenia?
   請說明受保人是否患有全血細胞減少。
   ☐ Yes 是 Please advise the latest blood test result and provide copy of blood test report. 請闡述最近的驗血結果並提供報告副本。

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   ☐ No 否

   iii. Does Insured suffer from any diffuse abnormal hardening of bones, multiple fracture and joint deformity?
   請說明受保人是否患有彌漫性骨骼異常硬化，多發性骨折及關節變形。
   ☐ Yes 是 Please advise the latest X-Ray studies result and provide copy of X-ray report. 請闡述最近的X光檢查結果及提供報告副本。

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   ☐ No 否

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SEVERE EPILEPSY 嚴重腦癇症

1. Please provide the underlying cause of seizures and provide copy of supportive EEG and MRI result and report.
請說明受保人痙攣的病因並提供確診的視頻腦電圖和磁力共振結果及報告。

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2. Please provide the dates of all attacks in the last six months and specify the type(s) of seizure (e.g. Febrile, absence (Petit Mal) seizures, partial seizures, generalised tonic-clonic seizure etc.)
請說明受保人於過去六個月的痙攣發作史並註明其痙攣種類（例如:熱性發作、失神發作（小發作）、局部發作、全身強直陣攣性發作等）。

Date of attack 發作日期	Type of seizure 痙攣種類
MM月 DD日 YYYY年	
MM月 DD日 YYYY年	
MM月 DD日 YYYY年	

3. Please provide all prescriptions during the last six months and advise any history of dosage adjustment according to Insured's conditions.
請提供過去六個月的抗痙攣藥物劑量並註明任何因定期監察抗痙攣藥物水平並按受保人情況所作出調節劑量的記錄。

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4. Did Insured perform neurosurgery to treatment epileptic seizures?
受保人是否曾接受神經外科手術治療腦癇症發作？

☐ Yes 是 Operation date 手術日期

MM月 DD日 YYYY年

Operation details 手術詳情

_____

☐ No 否

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TOURETTE SYNDROME 妥瑞症

1. Based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), please provide details for those met.
根據精神疾病診斷及統計手冊 (DSM-5)，請提供符合條件的詳情。

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2. Please provide all existing therapeutic intervention.
請提供受保人正接受的治療詳情。

Date 日期	Treatments / Therapies 治療
MM月 DD日 YYYY年	
MM月 DD日 YYYY年	
MM月 DD日 YYYY年	
MM月 DD日 YYYY年	

3. Please advise if the signs and symptoms of the diagnosed condition interfere with or reduce the quality of social and / or academic functioning?
請說明所診斷疾病之徵狀是否干擾或降低社交及 / 或學術功能的質素。

☐ Yes 是 Please advise details. 請提供詳情。

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☐ No 否

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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。

Name of Attending Physician / Specialist (with qualifications) 主診 / 專科醫生的姓名（資歷）	Signature (with chop) 簽名（蓋印）
Address and Telephone No. 地址及電話	Date 日期

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