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－LOSS OF SIGHT IN ONE EYE
危疾－單眼失明

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：_____

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。
_____
_____

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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. Please describe the extent of the loss. 請描述該傷患之狀況。
   i. Date of onset. 病發 / 意外日期:
   MM月 DD日 YYYY年
   ii. Which eye is involved? 請指出受影響而喪失視力的眼睛。
   Eye 眼睛： ☐ Right Eye右眼 ☐ Left Eye 左眼
   Please indicate the best visual acuity of the involved eye with and without correction aid.
   請指出受影響的眼睛在有矯視或沒有矯視的情況下之最佳視力。
   _____
   Is the loss of sight of the eye considered complete and permanent?
   該眼喪失視力的狀況是否屬於完全及永久性的？？ ☐ Yes 是 ☐ No 不是

3. What was the cause of loss of Sight of the Eye? 喪失一眼視力是因何引致？

   ☐ Illness 疾病：_____

   ☐ Accidental Injury 意外受傷：_____

   ☐ Self-inficted Injury 自致的受傷：_____

   ☐ Others 其他：_____

7. Please enclose copies of all surgical reports, X-rays, CT scans, and any other imaging studies, laboratory evidence, angiograms, 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、及其他影像報告、化驗報告及血管造影術報告等，或任何有關的醫院報告。

8. 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。

9. 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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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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I / We confirm that I / we have read, understood and agreed to the Personal Information Collection Statement(s) of my / our policy issuer(s) and / or pension scheme provider(s), i.e. AIA International Limited (Hong Kong Branch), AIA International Limited (Macau Branch), AIA Company Limited and / or AIA Everest Life Company Limited, where applicable, (the "PICS") which is available for download: https://www.aia.com.hk/en/privacy-statement-main.

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I / We acknowledge and consent to the transfer of my / our personal data to parties within or outside Hong Kong (for policy(ies) / pension scheme(s) issued in Hong Kong) or Macau (for policy(ies) / pension scheme(s) issued in Macau), as the case may be, for the purposes as set out in the PICS.

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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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