AIA

CRITICAL ILLNESS－STROKE 危疾－中風

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

O3410033

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. 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 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

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：_____

Policy Number 保單號碼 | | | | | | | | | | |

OTHER / 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。

Name of physician / facility 醫生姓名或醫院名稱	Address 地址	Date of consultation / confinement period (MM/DD/YYYY) 求診日期 / 住院時段（月/日/年）

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。

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 and 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? 眼或視神經或前庭系統功能造成影響的血管疾病？ ☐ Yes 是 ☐ No 否

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）。

_____

Please enclose copies of all reports including all reports, radiological procedures, MRI, CT scanning, laboratory evidence, other imaging studies, laboratory evidence, other imaging procedures, etc. and any relevant hospital reports that are available. 請提供所有診斷報告，如X光檢查、電腦掃描、超聲波、化驗報告及其他圖象報告等，或任何有關的醫院報告。

4. Details of medical treatment rendered. 請列出受保人曾接受之治療詳情。

Date 日期 (MM/DD/YYYY 月/日/年)	Treatment 治療項目

5. Is there any neurological sequelae resulted from the stroke? 是次中風有沒有引發神經後遺症？ ☐ Yes 是 ☐ No 否

If "yes", please state the details of neurological sequelae: 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？

_____

Policy Number 保單號碼 | | | | | | | | | | |

6. Are there any predisposing factors leading to the Insured's stroke (e.g. hypertension, heart diseases or diabetes mellitus, etc.). If so, please give details and history of such. 是否有其它傾向性因素導致受保人之中風（如高血壓，心臟病或糖尿病等）？如有，請提供該等因素之詳情及病史。

7. 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。

8. 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。

PERSONAL DATA COLLECTION AND USE

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.

I / We declare and agree that any personal data and other information relating to me / us or my / our policy(ies), account(s) or investments contained in this application or collected, obtained, compiled or held by my / our policy issuer(s) and / or pension scheme provider(s) by any means from time to time may be collected and utilized in accordance with the PICS.

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.

The latest version of the PICS which complies with the relevant rules and regulations is / are available for download from the above website and upon request.

個人資料收集及使用

我 / 我們確認我 / 我們已閱讀、明白及同意我 / 我們的保單繕發人及 / 或退休金計劃服務提供者（即友邦(國際)有限公司（香港分行）、友邦(國際)有限公司（澳門分行）、友邦保險有限公司及 / 或友邦售峰人壽有限公司（如適用））的個人資料收集聲明（「該聲明」），該聲明可在以下網址下載 https://www.aia.com.hk/zh-hk/privacy-statement-main。

我 / 我們聲明及同意在本申請所載或我/我們的保單繕發人及 / 或退休金計劃服務提供者不時以任何方法收集、獲得、編製或持有的任何個人資料及關於我 / 我們的保單、帳戶或投資的其他資料，可根據該聲明收集及使用。

我 / 我們知悉及同意就該聲明所述目的轉移我 / 我們的個人資料至香港境外 / 境內（如保單 / 退休金計劃在香港繕發）或澳門境外 / 境內（如保單 / 退休金計劃在澳門繕發）（視乎情況而定）予該聲明所載的資料承讓人。

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。

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

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

Download our AIA+ mobile app to manage your policy!
下載 AIA+ 手機應用程式以便輕鬆管理您的保單！

"AIA" shall refer to AIA International Limited (Incorporated in Bermuda with limited liability), AIA Company Limited (Incorporated in Hong Kong with limited liability), as the case may be, depending on the issuing company of the relevant insurance policies this form is subject to.
「AIA」或「友邦」指友邦保險(國際)有限公司（於百慕達註冊成立之有限公司），友邦保險有限公司（於香港註冊成立之有限公司）（視情況而定），具體取決於此信件相關表格的簽發公司。