AIA

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－STROKE 危疾－中風

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。

_____

_____

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?
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？

_____

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。

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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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