AIA

CRITICAL ILLNESS－CANCER / EARLY STAGE MALIGNANCY
危疾－癌 / 早期惡性腫瘤

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	O3420036

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? ☐ Yes 有 ☐ No 沒有
受保人是否有同類之病史。

   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：_____

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

2. Is the tumour histologically classified as pre-malignant, non-invasive, carcinoma-in-situ, or having borderline malignancy or low malignant potential? 腫瘤是否在任何在組織學中分類為癌前病變、非浸潤性、原位癌，或交界性或低惡性潛力的腫瘤？

   ☐ Yes 是 Please provide details 請提供詳情 ☐ No 否

3. (a) What is the staging of the tumour according to the TNM classification system? 根據TNM評級系統，此腫瘤屬於哪一級別？

   (b) Is there any clear stromal invasion by the tumour? 腫瘤有否明顯入侵基質？

   ☐ Yes 是 Please provide details 請提供詳情 ☐ No 否

   (c) What is the site of primary tumour? 腫瘤的原發器官？

   (d) Is there any distant metastasis? 腫瘤有否擴散至其他器官？

   ☐ Yes 是 Please provide details 請提供詳情 ☐ No 否

   (e) What tests were performed to confirm the diagnosis? (Please enclose copies of all relevant laboratory reports and medical reports)
   已進行什麼檢驗項目確定此診斷？（請提供所有有關檢驗報告及醫療報告副本）

Test Date 檢驗日期	Test Item 檢驗項目	Result / Histopathological Diagnosis 結果 / 病理最後診斷
MM月 DD日 YYYY年		
MM月 DD日 YYYY年		
MM月 DD日 YYYY年		
MM月 DD日 YYYY年		
MM月 DD日 YYYY年		

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4. (a) If the diagnosis is leukaemia, please state the type. 如診斷為白血病，請提供白血病之類別。

(b) If the diagnosis is Chronic Lymphocytic Leukemia, please state the RAI Stage. 如診斷為慢性淋巴性白血病，請提供其RAI級別。

5. Is the Insured infected with Human Immunodeficiency Virus (HIV)? 受保人有否感染人體免疫力缺乏病毒(HIV)？

☐ Yes 是 Please provide details 請提供詳情 ☐ No 否

6. Please provide current treatment details. 請提供現時接受治療的詳情。

☐ Surgical 外科手術 ☐ Radiotherapy 放射性治療

☐ Chemotherapy 化學治療 ☐ Palliative 姑息治療

☐ Others, please specify: 其他，請註明：

7. Has the Insured suffered from or been treated for any other major illnesses in the past? 請列明受保人曾患上或接受治療的其他主要疾病。

☐ Yes 是 Please provide details 請提供詳情 ☐ No 否

8. Is there any further information that 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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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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