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－PARKINSON'S DISEASE / LESS SEVERE PARKINSON'S DISEASE
危疾－柏金遜症 / 次級嚴重柏金遜症

GENERAL INFORMATION －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：_____

7. Other physicians or medical facilities the patient has consulted for this condition.
受保人曾經就診之其他醫生或醫療機構資料。

Name of physician / facility 醫生 / 機構名稱	Address 地址	Date of consultation / confinement period 求診日期 / 住院時段

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。

DETAILS OF THE INSURED'S ILLNESS 受保人病況之詳情

8. 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。

9. Please describe the extent of the disease.請描述該疾病之狀況。

i Date of oneset 病發日期

MM月 DD日 YYYY年

ii. What was the diagnosis? 請提供該病之診斷結果。

iii. Was the diagnosis confirmed by a neurologist? 是否經腦神經專科醫生確診？ ☐ Yes 是 ☐ No 否

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。

iv. What is the cause of the disease? 該病因何引致？

☐ Idiopathic 原發性 ☐ Drug Induced 藥物引發 ☐ Caused by toxic 由中毒導致

☐ Others 其他：

v. Is the condition controllable by medicine? 病情是否受藥物控制？ ☐ Yes 是 ☐ No 否

Please give details. 請提供詳情。

vi. Is there any progressive impairment documented 有否記錄顯示病人的症狀逐漸轉壞？ ☐ Yes 是 ☐ No 否

Please give details. 請提供詳情。

10. (a) Is the Insured able to perform without assistance the following: 受保人是否能在不受輔助的情況下完成以下之活動：

i Getting in and out of a chair or bed without requiring any physical assistance.
在無需任何幫助的情況下，可自行上落床、坐椅及自椅子起立。 ☐ Yes 是 ☐ No 否

ii Ability to move from room to room without requiring any physical assistance.
在無需任何幫助的情況下，可自行由某一間房間移動至另一間房間。 ☐ Yes 是 ☐ No 否

iii The ability to voluntarily control bladder and bowel functions so as to maintain personal hygiene.
有控制膀胱及大腸功能的自發能力，以保持個人衛生。 ☐ Yes 是 ☐ No 否

iv Putting on and taking off all necessary items of clothing without requiring the assistance of another person.
在無需其他人士幫助的情況下，可自行穿著及除掉一切所需衣物。 ☐ Yes 是 ☐ No 否

v. he ability to wash oneself in the bath or shower (including getting in or out of the bath or shower) or wash oneself by any other means.
可自行在浴缸或淋浴間進行沐浴或淋浴（包括進出浴缸或淋浴間）或使用其他方式洗澡的能力。 ☐ Yes 是 ☐ No 否

vi All tasks of getting food into the body once it has been prepared.
進食已預備好之食物的一切程序。 ☐ Yes 是 ☐ No 否

(b) How long have such inabilities been medically documented? 根據醫學證據，上列的活動能力已喪失了多久？

(c) Is such inability expected to be permanent? 已喪失的活動能力是否屬於永久性的？ ☐ Yes 是 ☐ No 否

Prognosis 病情進展

11. Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedures, etc. and any relevant hospital reports that are available.
請提供所有報告包括放射性治療程序、電腦掃描、化驗報告、其他影像報告等，或任何有關的醫院報告。

12. 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。

13. 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。

I / We hereby declare that the information given on this form is true and complete to the best of my / our knowledge and belief.
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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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