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－ENCEPHALITIS / LESS SEVERE ENCEPHALITIS
危疾－腦炎 / 次級嚴重腦炎

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. Etiology. 病因。

3. The site of the inflammation. 腦炎的正確位置。

4. 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，請提供確診之腦神經專科醫生之姓名及地址。

   _____

5. Has any investigation been done to prove acute viral infection of the brain?
   有沒有透過任何檢查項目以証明為急性病毒感染的腦炎？ ☐ Yes 有 ☐ No 沒有
   If "yes", please state all the investigations done. 如"有"，請列出所有檢查項目詳情：

Dates 日期	Procedures 檢查項目 / 名稱	Results 結果

   Note : Please enclose copies of all reports, including biopsy reports, cytology reports, X-rays, CT scans, MRI and other imaging studies, laboratory tests, surgical report, etc. and any relevant hospital reports that are available.
   備註：請提供所有報告包括活體檢視記錄、細胞分析報告、X 光檢查、電腦掃描、磁力共震、其他影像、化驗及手術報告等，或任何有關的醫院報告。

6. Was hospitalization required due to Encephalitis? 有否因為腦炎而需要接受住院治療？ ☐ Yes 有 ☐ No 沒有
   If "yes", please state the period(s) of hospital confinement(s). 如"有"，請列出住院時段。
   From 由 ☐☐ MM月 ☐☐ DD日 ☐☐☐☐ YYYY年 To 至 ☐☐ MM月 ☐☐ DD日 ☐☐☐☐ YYYY年
   Name of Hospital 醫院名稱：_____
   Name of Attending doctor 主診醫生名稱：_____ 日

7. Was there any surgery performed? 受保人有否接受手術治療？ ☐ Yes 有 ☐ No 沒有
   If "Yes", please state the details of the surgical procedure(s)? 如"有"，請列出該手術之詳情。

   _____

   _____

8. Was Encephalitis resulted from HIV Infection? 腦炎是否由人體免疫力缺乏病毒(HIV)引致？ ☐ Yes 是 ☐ No 不是

9. Is there any significant and serious permanent neurological defect resulted?
   有沒有因腦炎導致永久性的神經虧損？ ☐ Yes 有 ☐ No 沒有
   If "yes", please give details of the defect and state how long it has been documented.
   如"有"，請提供神經虧損之狀況及該狀況約存在了多久？

10. Prognosis. 病情進展。

11. 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。

12. 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.
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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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