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－ELEPHANTIASIS
危疾－象皮病

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. 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。

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

7. 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。

8. Etiology? 病因為何？

9. Is the diagnosis confirmed by a consultant specialist?
診斷是否由專科醫生確認？ ☐ Yes 是 ☐ No 否

Please state the name and address of the consultant specialist. 請提供專科醫生的姓名和地址。

_____

10. Is there any massive swelling in the body tissues?
身體組織有否出現全面腫大的情況？ ☐ Yes 是 ☐ No 否

Is there any obstruction in the blood and lymphatic vessels?
血管及淋巴管有否受阻？ ☐ Yes 是 ☐ No 否

11. Investigations done (dates, procedures, results). 檢查詳情（日期、檢查項目、結果）。

Dates 日期	Procedures 檢查項目	Results 結果

Note : Please enclose copies of all reports, including biopsy reports, cytology reports, X-rays, CT scans, MRI, USG 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、磁力共振、超聲波、其他影像、化驗及手術報告等，或任何有關的醫院報告。

12. Details of treatment rendered. 治療詳情：

_____

Was there any surgery performed? 受保人有沒有接受手術治療？ ☐ Yes 有 ☐ No 沒有

If "Yes", please state details of surgical procedure(s) 如"有"，請列出曾接受之手術名稱。

_____

13. Present condition of the insured 受保人現時之病況。

14. Prognosis 病情進展：

19. 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。

20. 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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