



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 |
| | |

FEMALE PRODUCT 女性保險

New Born Baby Congenital Anomaly 新生嬰兒先天性異常 – DOWN'S SYNDROME 唐氏綜合症

Down's Syndrome shall mean a specific chromosomal abnormality, specifically an autosomal aberration, identified by an extra chromosome 21 and characterized by muscular hypotonicity, microcephaly, brachycephaly and a flattened occiput. Physical and mental retardation are normally observed during the early stages of childhood. This anomaly can be detected either through prenatal testing such as chorionic villus sampling, amniocentesis or a triple screen blood test and chromosome examination / analysis of both parents.

「唐氏綜合症」是指一種特殊的染色體異常，具體地說是常染色體畸變，可透過21號染色體超數確認，主要特徵為肌張力減退、小頭畸形、短頭畸形及枕骨扁平。身體及智力發展遲緩一般可在兒童期早期發現。此異常情況可以透過產前檢查，如絨毛膜抽驗、羊膜穿刺術或三重血液測試，及父母染色體檢驗/分析而確定。

| <p>1. Are you the Insured's usual medical physician? 閣下是否受保人慣常求診之醫生？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>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？</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>MM月 DD日 YYYY年</p> <p>If "no", do you know who is her usual medical physician? 如“否”，請問受保人慣常求診之醫生是誰？</p> <p>_____</p> | <p>Details of "Yes" answers (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities).</p> <p>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。</p> | | | | | | | | | | | |
|--|--|---|---------------|---|--|--|--|--|--|--|--|--|
| <p>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。</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>MM月 DD日 YYYY年</p> | | | | | | | | | | | | |
| <p>3. Is there an extra chromosome 21? 第二十一對染色體是否異常地多了一個常染色體？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> | | | | | | | | | | | | |
| <p>4. Does the patient exhibit the below symptoms? 患者是否有下列徵兆？</p> <p>a. muscular hypotonicity 有肌張力減退 <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>b. microcephaly / brachycephaly 小頭畸形 / 短頭畸形 <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>c. flattened occiput 枕骨扁平 <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> | | | | | | | | | | | | |
| <p>5. What is the nature and extent of retardation of physical and mental development? 體格及智力發育遲緩的性質及程度。</p> | | | | | | | | | | | | |
| <p>6. 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？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> | | | | | | | | | | | | |
| <p>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。</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name of physician / facility 醫生 / 機構名稱</th> <th style="width: 30%;">Address 地址</th> <th style="width: 40%;">Date of consultation / confinement period 求診日期 / 住院時段</th> </tr> </thead> <tbody> <tr> <td style="height: 30px;"></td> <td></td> <td></td> </tr> <tr> <td style="height: 30px;"></td> <td></td> <td></td> </tr> <tr> <td style="height: 30px;"></td> <td></td> <td></td> </tr> </tbody> </table> | | 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 | | | | | | | | |
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DETAILS OF THE INSURED'S ILLNESS 受保人病況之詳情

8. How long has the condition been medically documented? 上述病症約存在了多久？

9. Please give details of clinical manifestations. 請提供臨床病徵之詳情。

10. Diagnostic tools e.g. chorionic villus sampling, amniocentesis or a triple screen blood test and chromosome examination/ analysis of both parents, including dates & results. (Please provide copies of reports for reference.) 確實有關診斷的檢驗詳情，如絨毛膜抽驗、羊膜穿刺術或三重血液測試，及父母染色體檢驗/分析，包括日期及結果。（請提供報告副本以供參考。）

11. Present condition & Prognosis of the insured. 受保人現時之病況及病情進展。

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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