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－CEREBRAL ANEURYSM REQUIRING SURGERY / ENDOVASCULAR TREATMENT FOR CEREBRAL ANEURYSM 危疾－須作手術之腦動脈瘤 / 大腦動脈瘤的血管介入治療

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：_____

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。

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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. Etiology. 病因。

10. The exact site of the cerebral aneurysm. 腦腫瘤所在的確實位置。

11. The size and histology of the cerebral aneurysm. 腦動脈瘤的體積及細胞組織分析。

12. Investigations: 檢查項目：

☐ X-ray X-光檢查 ☐ CT Scan 電腦掃描

☐ MRI 磁力共振 ☐ Frozen Section / Biopsy 冰凍切片 / 細胞組織活檢

Others 其他：_____

Note : Please enclose copies of all pathological, laboratory, surgical and imaging reports for reference.
備註：請提供所有報告包括病理、化驗、手術及其他影像等報告。

13. Has the patient undergone surgical correction for cerebral aneurysm?
病人有否就腦動脈瘤接受矯正手術？ ☐ Yes 有 ☐ No 沒有

If "Yes", the type of surgical procedure performed? 如"有"，進行了何種手術程序？

(a) Intracranial surgery through a craniotomy 透過顱骨切開術進行顱內手術 ☐ Yes 有 ☐ No 沒有

(b) Endovascular intervention procedures such as endovascular embolization, endovascular coiling, angioplasty and/or stenting or the insertion of a flow diverter
進行血管介入治療，如經血管內栓塞治療、經血管內盤繞治療、血管成形術及 / 或植入支架或置入流量分流器 ☐ Yes 有 ☐ No 沒有

(c) If any one of the above 2 questions is "Yes", please specify the name of the procedure done for cerebral aneurysm:
如以上兩項任何一項為"有"，請列出就腦動脈瘤進行的手術程序名稱：

_____

(d) If none of the above surgeries has been done, please state what other types of surgery was performed.
如沒有進行上述手術，請列出所進行之其他矯正手術。

_____

(e) Date and place of surgery 手術日期及地點

Date of surgery 手術日期：

MM月 DD日 YYYY年

The hospital where the surgery was performed 手術醫院：_____.

Name of Surgeon 手術醫生姓名：_____

(f) The surgery was performed for: 進行之手術用作：

☐ Clipping an aneurysm of cerebral arteries 夾剪腦動脈內的動脈瘤

☐ Repairing an aneurysm of cerebral arteries 修復腦動脈內的動脈瘤

☐ Removing an aneurysm of cerebral arteries 切除腦動脈內的動脈瘤

☐ Preventing rupture of a cerebral aneurysm 預防大腦動脈瘤破裂

☐ Alleviating the bleeding due to rupture of a cerebral aneurysm 減輕因大腦動脈瘤破裂而導致出血

☐ Others (please specify) : 其他（請註明）：_____.

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14. Present condition and prognosis. 現時之病況及病情進展。

15. 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。

16. 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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