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－AIDS DUE TO BLOOD TRANSFUSION
危疾－因輸血而感染愛滋病

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。

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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. Please describe the extent of the disease. 請描述該病之狀況。

   i. Approximate date of onset. 病發日期：

   MM月 DD日 YYYY年

   ii. Was the HIV Infection due to a medically necessary blood transfusion?
   受保人人體免疫力缺乏病毒感染是否因醫療所需輸血而導致？ ☐ Yes 是 ☐ No 不是

   If "Yes", why was blood transfusion medically required? Please give details. 如"是"，受保人為什麼需要接受輸血? 請提供詳情。

   _____

   Was the source of the infection established to be contaminated blood provided for the blood transfusion and the origin of which can be traced through the institution?
   是否確定受感染之源頭是用作輸血的受污染之血液，並可透過提供該受污染之血液的機構追查其來源？ ☐ Yes 是 ☐ No 不是

   When and where was the blood transfusion performed? 該輸血於何時及哪裡進行?

   MM月 DD日 YYYY年

   Name and Address of the Institution 輸血之機構名稱及地址：

   _____

   Did the institution admit any liability for the HIV infection?
   該負責輸血的機構有否承認須為導致該人體免疫力缺乏病毒感染而負責？ ☐ Yes 有 ☐ No 沒有

   iii. Does the insured suffer from Thalassaemia Major?
   受保人有否罹患重型地中海貧血？ ☐ Yes 有 ☐ No 沒有

   If "Yes", since when did the insured suffer from Thalassaemia Major? 如"有"，受保人於何時開始罹患重型地中海貧血？

   MM月 DD日 YYYY年

   iv. Does the insured suffer from Haemophilia? 受保人有否罹患血友病？ ☐ Yes 有 ☐ No 沒有

   If "Yes", since when did the insured suffer from Haemophilia? 如"有"，受保人於何時開始罹患血友病？

   MM月 DD日 YYYY年

   v. What forms of treatment were rendered? 受保人曾接受哪一種治療？

   _____

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

11. Please enclose copies of all reports including X-rays, blood tests, other laboratory tests, surgical procedures and any relevant hospital reports that are available.
    請提供所有報告包括X光檢查，驗血，其他化驗報告及手術報告等，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。

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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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