

**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 <div></div> | |
| Name of Insured 受保人姓名 <div></div> | ID Card / Passport No. 身分證 / 護照號碼 <div></div> |

CRITICAL ILLNESS – CREUTZFELD-JACOB DISEASE / LESS SEVERE CREUTZFELD-JACOB DISEASE 危疾 – 庫賈氏病 / 次級嚴重庫賈氏病**GENERAL INFORMATION – 一般資料**

| <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？ <div><div></div><div></div><div></div><div></div><div></div><div></div></div> MM月 DD日 YYYY年</p> | <p>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。</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。 <div><div></div><div></div><div></div><div></div><div></div><div></div></div> MM月 DD日 YYYY年</p> <p>What were the symptoms? 受保人之病徵。 <div></div></p> <p>How long had the symptoms been present? 該病徵約存在了多久？ <div></div></p> | | | | | | | | | | | | |
| <p>3. Has the Insured previously suffered from this illness or any related conditions? 受保人是否有同類之病史？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>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。 <div></div></p> | | | | | | | | | | | | |
| <p>4. On which date was the diagnosis made? 有關疾病之診斷是何時首次確認？ <div><div></div><div></div><div></div><div></div><div></div><div></div></div> MM月 DD日 YYYY年</p> <p>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？ <div><div></div><div></div><div></div><div></div><div></div><div></div></div> MM月 DD日 YYYY年</p> | | | | | | | | | | | | |
| <p>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？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> | | | | | | | | | | | | |
| <p>6. Is the Insured a smoker? 受保人是否吸煙人仕？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>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：_____</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"><thead><tr><th>Name of physician / facility 醫生 / 機構名稱</th><th>Address 地址</th><th>Date of consultation / confinement period 求診日期 / 住院時段</th></tr></thead><tbody><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></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 | | | | | | | | |
| 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 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.

請描述該疾病之狀況。

i What is the onset age of Creutzfeld-Jacob Disease?

發病之年齡。

ii Was there any incurable brain infection that causes rapidly progressive deterioration of mental function and movement?

是否出現不可治癒的腦部感染，導致急劇而漸進性的智力功能與活動衰退？

iii The diagnosis above is confirmed based on which of the following(s):

其診斷結果是否由以下證實：

1. Clinical assessment 臨床測試

☐ Yes 是

☐ No 否

2. EEG 腦電圖

☐ Yes 是

☐ No 否

3. Imaging 掃描影像

☐ Yes 是

☐ No 否

4. Lumbar puncture 腰椎穿刺

☐ Yes 是

☐ No 否

If "yes", please provide the relevant report. 如“是”，請提供有關報告。

Was the diagnosis confirmed by other methods which are not mentioned above?

病人是否曾接受上述以外的診斷方法而證實患上庫賈氏病？

☐ Yes 是

☐ No 否

If "yes", please state the method and provide the relevant report.

請列明該診斷方法及提供有關報告。

iv. Was the disease caused by human growth hormone treatment?

該病是否由人類生長激素治療引致的？

☐ Yes 是

☐ No 否

v. What forms of treatment were rendered?

受保人曾接受哪一種治療？

10. Was the diagnosis confirmed by a specialist?

此疾病是否經專科醫生確診？

☐ Yes 是

☐ No 否

Please give name, address and specialty of the specialist confirming the diagnosis if it is not the undersigned.

若非由填寫此表格之醫生確診，請提供確診之專科醫生之姓名，地址及專科。

11. Please enclose copies of all reports including all reports, radiological procedures, MRI, CT scanning, electroencephalography, biopsy, laboratory evidence, other imaging studies, etc. and any relevant hospital reports that are available.

請提供所有報告，如放射性治療、磁力共振、電腦掃描、腦電圖、活體檢驗記錄、化驗報告及其他影像報告等，或任何有關的醫院報告。

12. Present condition and prognosis.

現時之病況及病情進展。

i Is the Insured bedridden?

受保人是否需要永久臥床？

☐ Yes 是

☐ No 否

ii. If Insured is not bedridden, which of the following daily activities the Insured is NOT able to perform as a direct result of the Creutzfeld-Jacob Disease. (please check the appropriate item)

如受保人不需永久臥床，受保人因庫賈氏病不能完成下列哪些日常生活活動？(請選擇適當的項目)

☐ Getting in and out of a chair or bed without requiring any physical assistance.

在無需任何幫助的情況下，可自行上落床、坐椅及自椅子起立。

☐ Ability to move from room to room without requiring any physical assistance.

在無需任何幫助的情況下，可自行由某一間房間移動至另一間房間。

☐ The ability to voluntarily control bladder and bowel functions so as to maintain personal hygiene.

有控制膀胱及大腸功能的自發能力，以保持個人衛生。

☐ Putting on and taking off all necessary items of clothing without requiring the assistance of another person.

在無需其他人士幫助的情況下，可自行穿著及除掉一切所需衣物。

☐ The ability to wash oneself in the bath or shower (including getting in or out of the bath or shower) or wash oneself by any other means. 可自行在浴缸或淋浴間進行沐浴或淋浴（包括進出浴缸或淋浴間）或使用其他方式洗澡的能力。

☐ All tasks of getting food into the body once it has been prepared.

進食已預備好之食物的一切程序。

iii. Is such inability expected to be permanent?

已喪失的活動能力是否屬於永久性？

☐ Yes 是

☐ No 否

13. 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。

14. 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.
本人 / 我們現聲明此申請書上所填資料皆為本人 / 我們所知及所信之事實及其全部。

PERSONAL DATA COLLECTION AND USE

I / We confirm that I / we have read, understood and agreed to the Personal Information Collection Statement(s) of my / our policy issuer(s) and / or pension scheme provider(s), i.e. AIA International Limited (Hong Kong Branch), AIA International Limited (Macau Branch), AIA Company Limited and / or AIA Everest Life Company Limited, where applicable, (the "PICS") which is available for download: <https://www.aia.com.hk/en/privacy-statement-main>.

I / We declare and agree that any personal data and other information relating to me / us or my / our policy(ies), account(s) or investments contained in this application or collected, obtained, compiled or held by my / our policy issuer(s) and / or pension scheme provider(s) by any means from time to time may be collected and utilized in accordance with the PICS.

I / We acknowledge and consent to the transfer of my / our personal data to parties within or outside Hong Kong (for policy(ies) / pension scheme(s) issued in Hong Kong) or Macau (for policy(ies) / pension scheme(s) issued in Macau), as the case may be, for the purposes as set out in the PICS.

The latest version of the PICS which complies with the relevant rules and regulations is / are available for download from the above website and upon request.

個人資料收集及使用

我 / 我們確認我 / 我們已閱讀、明白及同意我 / 我們的保單繕發人及 / 或退休金計劃服務提供者（即友邦（國際）有限公司（香港分行）、友邦（國際）有限公司（澳門分行）、友邦保險有限公司及 / 或友邦雋峰人壽有限公司（如適用））的個人資料收集聲明（「該聲明」），該聲明可在以下網址下載

<https://www.aia.com.hk/zh-hk/privacy-statement-main>。

我 / 我們聲明及同意在本申請所載或我 / 我們的保單繕發人及 / 或退休金計劃服務提供者不時以任何方法收集、獲得、編製或持有的任何個人資料及關於我 / 我們的保單、帳戶或投資的其他資料，可根據該聲明收集及使用。

我 / 我們知悉及同意就該聲明所述目的轉移我 / 我們的個人資料至香港境外 / 境內（如保單 / 退休金計劃在香港繕發）或澳門境外 / 境內（如保單 / 退休金計劃在澳門繕發）（視乎情況而定）予該聲明所載的資料承讓人。

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



Download our AIA+ mobile app to manage your policy!
下載 AIA+ 手機應用程式以便輕鬆管理您的保單！

"AIA" shall refer to AIA International Limited (Incorporated in Bermuda with limited liability), AIA Company Limited (Incorporated in Hong Kong with limited liability), as the case may be, depending on the issuing company of the relevant insurance policies this form is subject to. 「AIA」或「友邦」指友邦保險（國際）有限公司（於百慕達註冊成立之有限公司），友邦保險有限公司（於香港註冊成立之有限公司）（視情況而定），具體取決於此信件相關表格的簽發公司。