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－SEVERE MYASTHENIA GRAVIS
危疾－嚴重重症肌無力

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：_____

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。

OTHER / ADDITIONAL INFORMATION 其他 / 附加資料

1. Please provide names, addresses and dates of doctors and hospitals which the Insured was referred and/or admitted to.
請提供受保人曾經就診之所有醫生姓名或醫院名稱及地址。

_____

_____

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

1. Please provide full and exact details of the diagnosis. 請提供該病之狀況及其診斷結果。

2. Please describe the extent of the disease. 請描述該病之狀況。
   (a) Was the autoimmune disorder of neuromuscular transmission acquired or congenital in nature?
   引致神經肌肉傳遞障礙之免疫性疾病是屬於先天還是後天性質?

   ☐ Acquired in nature 後天性質 ☐ Congenital in nature 先天性質

   If "Acquired in nature", how was it confirmed? 如是"後天性質"，是如何確定?

   _____

   (b) Did it lead to fluctuating muscle weakness and fatiguability?
   有否導致波動性之肌無力及容易疲勞？ ☐ Yes 有 ☐ No 沒有

   If "yes", please describe the overall condition. 如"有"，請形容其狀況。

   _____

   (c) Was there permanent muscle weakness? 永久出現肌無力？ ☐ Yes 是 ☐ No 否

   If "yes", please describe which muscle and the level of weakness. 如"是"，請指出受影響的肌肉及其肌無力的程度。

   _____

   (d) What is the class of the Insured's muscle weakness according to the Myasthenia Gravis Foundation of America Clinical Classification?
   根據美國重症肌無力基金會的臨床分類, 受保人的重症肌無力屬於何種分類?

   ☐ Class I – Any eye muscle weakness, possible ptosis, no other evidence of muscle weakness elsewhere
   I級 – 任何眼部肌肉無力，可能性之上瞼下垂，及並無其他部位出現肌無力的證據。

   ☐ Class II – Eye muscle weakness of any severity, mild weakness of other muscles
   II級 – 任何程度之眼部肌肉無力，及其他部位之輕度肌肉無力。

   ☐ Class III – Eye muscle weakness of any severity, moderate weakness of other muscles
   III級 – 任何程度之眼部肌肉無力，及其他部位之中度肌肉無力。

   ☐ Class IV – Eye muscle weakness of any severity, severe weakness of other muscles
   IV級 – 任何程度之眼部肌肉無力，及其他部位之嚴重肌肉無力。

   ☐ Class V – Intubation needed to maintain airway
   V級 – 需要插管以維持氣管暢通。

   (e) Was the diagnosis confirmed by a neurologist? 是否經腦神經專科醫生確診？ ☐ Yes 是 ☐ No 否

   (f) Please give Name and Address of the neurologist confirming the diagnosis if it is not the undersigned.
   若非由填寫此表格之醫生確診，請提供確診之腦神經專科醫生之姓名及地址。

   _____

3. What treatment received by patient? 病人接受何種治療？
   (a) 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"，請列出手術詳情。

   Date 日期：
   ☐☐ ☐☐ ☐☐☐☐
   MM月 DD日 YYYY年

   Name of Surgical Procedure 手術名稱：_____

   Place 地點：_____ Name of Surgeon 手術醫生姓名：_____

   (b) Other treatment: 其他治療：

   _____

   _____

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

5. Please enclose copies of all reports including, X-rays, CT scans, blood tests, electromyography, pulmonary function test and any other imaging studies, laboratory evidence, etc. and any relevant hospital reports that are available.
   請提供所有報告包括X光檢查、電腦掃描、驗血報告、肌動電流描記術、肺功能測試及其他影像報告、化驗報告等，或任何有關的醫院報告。

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6. 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。

7. 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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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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