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－SYSTEMIC SCLERODERMA
危疾－系統性硬皮病

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) Which of the below organs / body parts was progressive diffuse fibrosis existed? 逐步彌漫性纖維化出現於下列哪一個器官/身體部位?

☐ Skin 皮膚 _____

☐ Blood Vessels 血管 _____

☐ Visceral Organs 內臟器官 _____

(b) Was the below condition existed? 是否有下列情況出現? Yes 是 No 不是

	Yes 是	No 不是
i. Pulmonary involvement 對肺功能之影響 :	☐	☐

Value of carbon monoxide diffusing capacity (DLCO) : < _____ % of predicted value

一氧化碳肺擴散容量少於預測值的百分比 : _____

Forced expiratory volume in 1 sec (FEV1) < _____ % of the predicted value

最大呼氣量（FEV1）少於預測值的百分比 : _____

Forced vital capacity (FVC) < _____ % of the predicted value

肺活量(FVC) 少於預測值的百分比 : _____

Total lung capactiy (TLC) < _____ % of the predicted value

肺總量(TLC)少於預測值的百分比 : _____

ii. Renal involvement 對腎功能之影響 :	☐	☐

Glomerular filtration rate (GFR) < _____ ml/min

腎小球濾過率(GFR)每分鐘少於 _____ 毫升

iii. Cardiac involvement 對心功能之影響 :	☐	☐

Any evidence of either congestive heart failure, cardiac arrhythmia requiring medication, or pericarditis with moderate to large pericardial effusion.
心臟受影響之證明為充血性心力衰竭、心律失常以致需服用藥物、或心包炎（中度至大量心包積液）。
If "Yes", please describe. 如"是"，請列明。

_____

_____

If any of the above answer is "yes", please enclose copies of the reports / documents that recorded the said history.
如上述任何一項為"是"，請提供相關的報告 / 文件。

(c) Is scleroderma localized? 硬皮病是否局部性？ ☐ Yes 是 ☐ No 否

(d) Is there any CREST syndrome? 是否有CREST 綜合症徵狀？ ☐ Yes 是 ☐ No 否

If "Yes", please specify: 如"是"，請註明：_____

(e) Was the diagnosis confirmed by a rheumatologist? 是否經風濕病專科醫生確診？ ☐ Yes 是 ☐ No 否
Please give Name and Address of the rheumatologist confirming the diagnosis if it is not the undersigned.
若非由填寫此表格之醫生確診，請提供確診之風濕病專科醫生之姓名及地址。

_____

3. Investigation done 檢查詳情：

Dates 日期	Procedures 檢查項目 / 名稱	Results 結果

Note : Please enclose copies of all reports, including biopsy reports, cytology reports, X-rays, CT scans, MRI, USG and other imaging studies, laboratory tests, surgical report, etc. and any relevant hospital reports that are available.
備註：請提供所有報告包括活體檢視記錄、細胞分析報告、X光檢查、電腦掃描、磁力共振、超聲波、其他影像、化驗及手術報告等，或任何有關的醫院報告。

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4. Details of treatment rendered. 治療詳情：

_____

_____

a. Was there any surgery performed? 受保人有沒有接受手術治療？ ☐ Yes 有 ☐ No 沒有

b. If "Yes", please state details of surgical procedure(s) 如"有"，請列出手術詳情。

_____

5. 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。

6. 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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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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