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－BILIARY TRACT RECONSTRUCTION SURGERY
危疾－膽道重建手術

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。
   _____
   _____

Policy Number 保單號碼 | | | | | | | | | | |

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

1. i. Has biliary tract reconstruction surgery performed? 有否進行膽道重建手術？ ☐ Yes 有 ☐ No 沒

If "yes", is choledochoenterostomy involved? 如"有"，有否包含膽管小腸吻合術？ ☐ Yes 有 ☐ No 沒

If "no", please specify the name of procedure. 請註明進行之手術名稱。

_____

ii. 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：_____

2. Please describe the extent of loss. 請描述損傷之狀況。

i. Date of onset of the biliary disease / trauma 膽道疾病病發或膽道創傷日期

MM月 DD日 YYYY年

ii. What is the condition leading to biliary tract reconstruction? 導致膽道需重建的狀況為何?

_____

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

4. Is the surgery due to biliary atresia?
手術治療是否由於膽道閉鎖引發？ ☐ Yes 是 ☐ No 否

5. Is there any known underlying cause(s) or precipitating illness(es) leading to the biliary condition? If so, please state any treatment history. 有沒有已知的原因或潛在的疾病引致膽道疾病發生？如有，請列出過往之治療記錄。

6. Please enclose copies of all reports including surgical reports, X-rays, CT scans, other imaging studies, laboratory evidence, angio grams, etc, and any relevant hospital reports that are available.
請提供所有報告包括手術報告，X-光檢查，電腦掃描，及其他影像報告，化驗報告及血管造影術報告等，或任何有關的醫院報告。

7. 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。

8. 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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