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－CEREBRAL SHUNT INSERTION
危疾－植入大腦內分流器

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. Date of onset of the brain condition 大腦疾病或創傷之病發日期。

   MM月 DD日 YYYY年

3. Cause of the brain condition 引致大腦疾病或創傷之原因。

4. i. Was cerebral shunt insertion done to the brain?
   有否進行大腦分流器植入手術？ ☐ Yes 有 ☐ No 沒有
   If "yes", please specify the location of the insertion. 如"有"，請列出植入分流器的位置。

   _____

   Date of the 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 手術醫生姓名 : _____

   ii. Was cerebral shunt insertion done to relieve raised pressure in the cerebrospinal fluid?
   進行大腦分流器植入手術是否用以舒緩已被提升腦脊液的壓力？ ☐ Yes 是 ☐ No 否
   If "no", what was the purpose of cerebral shunt insertion? 如"否"，進行大腦分流器植入手術的目的為何？

   _____

   iii. Was the shunt surgery certified to be medically necessary by a neurologist?
   植入分流器手術是否由腦神經專科醫生證實為醫療所需？ ☐ Yes 是 ☐ No 否
   Please give the Name and Address of the neurologist if it is not the undersigned. 若非由填寫此表格之醫生確認，請提供腦神經專科醫生之姓名及地址。

   _____

5. Please enclose copies of all surgical reports, X-rays, MRI, CT scans, and any other imaging studies, laboratory evidence, etc. and any relevant hospital reports that are available.
   請提供所有手術報告、X光檢查、磁力共振、電腦掃描、及其他圖象報告、化驗報告等，或任何有關的醫院報告。

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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