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－STILL'S DISEASE
危疾－斯蒂爾病

GENERAL INFORMATION －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。

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   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？

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   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？

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   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. 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。

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 "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。

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

7. How long has the condition been medically documented? 上述病症約存在了多久？

8. Results & dates of following laboratory test (Please provide copy of test results):
接受下列化驗的日期及其結果﹙請提供報告副本以供參考。﹚

Name of Laboratory Test 化驗項目	Results 化驗結果	Dates (MM/DD/YYYY) 日期（月/日/年）

Note: please enclose copies of all reports, including blood test, biopsy reports, cytology reports, x-rays, CT scans, other imaging studies, laboratory evidence, surgical report etc. and any relevant hospital reports that are available.
註: 請提供所有報告包括血液化驗，活體檢視記錄，細胞分析報告，X-光檢查，電腦掃描，其他化驗報告，手術報告，或任何有關的醫院報告。

9. What was the cause of the disease? 該疾病是因何引致？

_____

_____

Was it congenital in nature? 該疾病是否由先天性殘缺或疾病而導致？ ☐ Yes 是 ☐ No 否

10. Was there widespread joint destruction resulted?
有否引致廣泛性關節破壞？ ☐ Yes 有 ☐ No 沒有

If "Yes", please list the joints involved and its condition. 如"有"，請列出受影響的關節及其狀況。

_____

_____

11. Details of treatment rendered 治療詳情：

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 provide details of surgical procedure(s) 如"有"，請提供手術詳情。

_____

If hip or knee replacement has been done, please give details. 如有進行髖或膝關節置換，請提供詳情：

Date of Surgery 手術日期：

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MM月 DD日 YYYY年

Procedure 手術程序：_____

The hospital where the surgery was performed 手術醫院：_____

Name of Surgeon 手術醫生姓名：_____

12 Present condition of the insured. 受保人現時之病況

13. Prognosis. 病情進展

14. 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。

15. 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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