AIA International Limited

(Incorporated in Bermuda with limited liability)

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）

SEVERITY-BASED HEALTH PROTECTION 嚴重程度健康保障

Policy Number 保單號碼

Name of Insured 受保人姓名

ID Card / Passport No. 身份證 / 護照號碼

GENERAL INFORMATION 一般資料

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。

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? 受保人是否吸煙人士？

   ☐ Yes 是 ☐ No 否

   If "Yes", what is his / her smoking habit? 若為吸煙人士，他 / 她 的吸煙習慣如何？

   Daily smoking amount 每日吸煙數量：______ for how many years? 吸食年數：______

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。

OPCLM145.0520

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

1. Please provide full and exact details of the diagnosis. 請提供受保人之所有及確定的診斷詳情。

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2. Is it a disease which is classified as a Public Health Emergency of International Concern by the World Health Organization (WHO)? 該疾病是否被世界衛生組織評定為國際關注的突發公共衛生緊急事件之疾病？

☐ Yes 是 ☐ No 否

3. How was the diagnosis confirmed? (Please state the details of diagnostic test / examination and its result if any) 受保人是如何被確診？（請提供相關診斷測試 / 檢查詳情及結果（如適用））

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PLEASE PROVIDE FURTHER DETAILS IF THE DIAGNOSIS IS CANCER / CARCINOMA-IN-SITU 如診斷結果為癌症 / 原位癌，請提供進一步資料

1. Is the diagnosis confirmed with histological examination? 診斷是否經病理分析確定？
   If yes, please provide the type and date of histological examination performed. 如是，請提供所作病理分析之類別及進行日期。

____

____

MM月 DD日 YYYY年

2. If histological examination is not done, what is the reason? 若未有進行病理分析，原因為何？

____

3. Histological result 病理分析結果
   i. Is the histological result carcinoma-in-situ? 病理分析結果是否原位癌？
      ☐ Yes 是 ☐ No 否
   ii. Is there uncontrolled growth of malignant cells? 癌細胞有否不受控制地生長？
      ☐ Yes 有 ☐ No 沒有
   iii. Is there any clear stromal invasion of malignant cells? 癌細胞有否明顯入侵基質?
      ☐ Yes 有 ☐ No 沒有
   iv. What is the staging of the cancer according to the TNM classification system? (For Chronic Lymphocytic Leukemia, please state the RAI Stage.) 根據TNM 評級系統， 此癌症屬於哪一階段？（慢性淋巴性白血病，則請列出其RAI級別。）

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   v. Is there any distant metastasis? If yes, any identified secondary site? 癌細胞有否擴散至其他器官？如有，已確認被擴散的器官？
      ☐ Yes 有 ☐ No 沒有

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4. Was the diagnosis confirmed by specialists? 此疾病是否經專科醫生確診？
   Please give name, address and specialty of the specialist confirming the diagnosis if it is not the undersigned.
   若非由填寫此表格之醫生確診，請提供確診之專科醫生之姓名，地址及專科。

____

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SEVERITY FACTOR－SURGERY 嚴重程度因素－手術

Was there any surgery performed? 受保人是否曾接受手術？ ☐ Yes 是 ☐ No 否

If yes, please provide the below details. 如是，請提供以下詳情。

1. Please provide the name, details and date of surgical procedure(s). 請提供手術名稱，詳情及日期。 MM月 DD日 YYYY年

2. Has the Insured already undergone organ transplantation or Is Insured on organ transplant waiting list? 受保人是否已接受器官移植手術或於主要器官移植之候補名單上？

   ☐ Yes 是 ☐ No 否

   If yes, please provide the details. If no, please skip to next Severity Factor. 如是，請提供詳情。如否，請繼續填寫下一個嚴重程度因素。

   a. Has the Insured already undergone organ transplantation? 受保人是否已接受器官移植手術？

      ☐ Yes 是

      i. Date of transplant 進行移植手術之日期： MM月 DD日 YYYY年

      ii. Place where the transplant was done 進行器官移植的地方：

      ☐ No, insured is on the Hong Kong Hospital Authority official organ transplant waiting list or the government-regulated official organ transplant waiting list in his / her residential country. 否，受保人於香港醫院管理局或其居住國家政府所監管的官方正式器官移植輪候冊名單上輪候移植。

      i Expected date of the transplant 預期進行移植手術之日期： MM月 DD日 YYYY年

      ☐ Others (please specify) 其他（請註明）

   b. What kind of organ transplant has the Insured undergone / been waiting to undergo as a recipient? 受保人已接受了 / 正在輪候接受下列哪種器官移植？

      ☐ Transplant of Human Organ 人體器官移植 (Name of organ involved 接受移植之器官：__________________)

      ☐ Transplant of Human Bone Marrow 人體骨髓移植

      i. Is bone marrow transplant preceded by total bone marrow ablation? 人體骨髓移植前是否會先進行全身骨髓消融？

         ☐ Yes 是 ☐ No 否

      ☐ Others (please specify) 其他（請註明）

   c. What cause the need for the organ transplant? 需要接受器官移植之原因。

   d. Was the diagnosis confirmed by two specialists? 此疾病是否經兩個專科醫生確診？
      Please give name, address and specialty of the specialist confirming the diagnosis if it is not the undersigned.
      若非由填寫此表格之醫生確診，請提供確診之專科醫生之姓名，地址及專科。

      Please enclose copies of reports from the specialists and all clinical and / or pathological evidence supporting such transplantation is provided. 請提供所有專科醫生診斷報告及醫療或 / 及病理報告證明已 / 將進行器官移植。

SEVERITY FACTOR－TREATMENT 嚴重程度因素－治療

Has insured undergone any treatment / therapy / medication ? 受保人是否曾接受治療 / 藥物治療 ? ☐ Yes 是 ☐ No 否

If yes, please provide the below details. 如是，請提供以下詳情。

1.

Name of Treatment / Therapy / Medication 治療 / 藥物治療名稱	Frequency / Dosage 次數 / 劑量	Period of treatment 治療日期	
		From 由	To 至

SEVERITY FACTOR－SEVERE HOSPITAL STAY 嚴重程度因素－嚴重住院

Was there any confinement? 受保人是否曾住院 ? ☐ Yes 是 ☐ No 否

If yes, please provide the below details.如是，請提供以下詳情。

1.

Hospital Name 醫院名稱	Confinement period 住院日期		Period in Intensive Care Unit 入住深切治療部日期	
	From 由	To 至	From 由	To 至

2. Was the insured suffer from Coma during the confinement? If yes, please give the below details. 受保人曾在住院期間昏迷？如是，請提供詳情。

   ☐ Yes 是 ☐ No 否

   a. Is there any reaction or response to external stimuli? 對外來刺激有沒有反應？

      ☐ Yes 有 ☐ No 沒有

      If no response, how long has it persisted? 如沒有反應，持續了多久？

      ____

   b. Is there any reaction or response to internal needs? 對體內需求有沒有反應？

      ☐ Yes 有 ☐ No 沒有

      If no response, how long has it persisted? 如沒有反應，持續了多久？

      ____

   c. Is there any permanent neurological defect? 有沒有永久性的神經機能缺損？

      ☐ Yes 有 ☐ No 沒有

   d. How long is it expected that the Insured will remain in coma? 請估計受保人之昏迷狀態會維持多久。

      ____

   e. What was the cause of the coma? 昏迷是因何引致？

      ____

   f. Was the coma directly resulted from self-inflicted injury? 是否直接因自致的傷害引致？

      ☐ Yes 是 ☐ No 否

   g. Was the coma directly resulted from alcohol or drug abuse? 是否直接因酒精或濫用藥物引致？

      ☐ Yes 是 ☐ No 否

ADDITIONAL INFORMATION 附加資料

1. Is HIV Infection present in the insured? 受保人有否感染人體免疫力缺乏病毒 (HIV)? ☐ Yes 有 ☐ No 沒有
   If yes, is there any complications of current claiming illness associated with HIV Infection? Please specify.
   如是，受保人所患的疾病是否受HIV感染的相關併發症？ 請列明。

   ____

Please enclose copies of all reports including X-rays, CT scans, ultrasound or other imaging studies, ECGs, surgical reports, laboratory evidence. Etc. and any relevant hospital reports that are available.
請提供所有手術報告、X光檢查、電腦掃描、超聲波及其他影像報告、心電圖、手術報告報告及化驗報告等，或任何有關的醫院報告。

I / We hereby declare that the information given on this form is true and complete to the best of my / our knowledge and belief.
本人 / 我們現聲明此申請書上所填資料皆為本人 / 我們所知及所信之事實及其全部。

PERSONAL DATA COLLECTION AND USE

PLEASE READ THE AIA PERSONAL INFORMATION COLLECTION STATEMENT (“AIA PIC”) BEFORE YOU SIGN THIS CERTIFICATE. IF THE AIA PIC STATEMENT IS NOT ATTACHED, YOU CAN ASK FOR A COPY FROM US. Also, the updated version of AIA PIC is available for download from its website: www.aia.com.hk.

All the personal data and other information contained in this Confidential Medical Certificate will be used by us for the processing of the Insured’s claim(s), and will also be utilized in accordance with AIA PIC. By completing and signing on this Certificate, you declare that the Insured / Owner has given you the express consent to release his / her personal data and other information to our Company and all transferees specified in the AIA PIC.

個人資料收集及使用

簽署此醫生報告前，請先閱讀**AIA**個人資料收集聲明。如**AIA**個人資料收集聲明未有隨附於本醫生報告，您可向我們索取複印本一份。**AIA**個人資料收集聲明的最新版本亦可於以下網址下載：**www.aia.com.hk** 。

所有個人及其他於此醫生報告收集所得的任何資料將會被我們用作處理受保人之索償申請，我們亦可根據**AIA**個人資料收集聲明使用該些資料。您填寫及簽署此醫生報告即表示您聲明受保人 / 保單持有人已授權您可於此報告透露他 / 她的個人資料及其他資料給我們或予**AIA**個人資料收集聲明所載的資料承讓人。

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 MM月 DD日 YYYY年

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