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－EARLY STAGE DEMENTIA INCLUDING EARLY STAGE ALZHEIMER'S DISEASE 危疾－早期腦退化症（包括早期亞爾茲海默氏症）

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. What is the age of onset of Dementia / Alzheimer's Disease? 發病之年齡。

_____

3. Was the diagnosis confirmed by a neurologist? 是否經腦神經專科醫生確診？ ☐ Yes 是 ☐ No 否

Please give Name and Address of the neurologist 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及地址。

_____

Is the insured still under care of and receiving on disease modifying treatment prescribed by the neurologist?
受保人是否仍然由腦神經專科醫生提供診治，並接受由該醫生處方的改善病情治療？ ☐ Yes 是 ☐ No 否

If "no", when was the last treatment date? 如"否"，最後治療日期為何？_____

4. Please describe the extent of the disease. 請描述該病之狀況。

i. Is there any cognitive impairment noted? 有沒有認知功能障礙？ ☐ Yes 有 ☐ No 沒有

If "yes", please provide details of cognitive impairment. 如"有"，請提供認知功能障礙之詳情。

_____

_____

ii. Has Mini Mental State Examination been done? 有沒有進行簡短智能測驗？ ☐ Yes 有 ☐ No 沒有

If "yes", how many times have been done? 如"有"，進行了多少次測驗？_____

When was / were the test(s) done and what was / were the score(s) out of 30? 測驗於何時進行及其分數在30分滿分的情況下取得多少分？

Date of Test Done 進行測試日期 Score 分數

_____ _____

iii. Has any other neuropsychometric test been done? 有沒有進行任何其他神經心理測量測試？ ☐ Yes 有 ☐ No 沒有

If "yes", please state all the test(s) done, date of test(s) done and result(s) of the test(s)? 如"有"，請列出所有曾進行的測試、測試進行日期及其結果

Tests done 測試項目 Date of Test Done 進行測試日期 Result / Score 結果 / 分數

_____ _____ _____

iv. Was there any imaging evidence to support the diagnosis of Dementia?
有沒有任何掃描影像報告支持腦退化症之診斷？ ☐ Yes 有 ☐ No 沒有

If "yes", please state the result. (Please also provide a copy of the report for reference.) 如"有"，請列出結果。(請提供報告作參考。)

_____

_____

5. Please enclose copies of questionnaires, test reports, imaging evidence or any relevant hospital reports that are available. 請提供所有報告包括相關之問卷、檢查報告、掃描影像及任何醫院報告。

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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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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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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