

**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 – TYPE I JUVENILE SPINAL AMYOTROPHY (SEVERE CHILD DISEASE)**危疾——型青少年脊髓性肌肉萎縮症 (嚴重兒童疾病)****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	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。											
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: _____												
7. 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。 <table border="1"><thead><tr><th>Name of physician / facility 醫生 / 機構名稱</th><th>Address 地址</th><th>Date of consultation / confinement period 求診日期 / 住院時段</th></tr></thead><tbody><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr></tbody></table>		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								
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DETAILS OF THE INSURED'S ILLNESS 受保人病況之詳情

8. 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。

9. Please describe the extent of the disease.

請描述該疾病之狀況。

i. Was there profound proximal muscular weakness and wasting?

是否出現逐漸由近端肌肉至遠端肌肉無力並萎縮？

If "yes", please describe the muscles involved.

如“是”，請列明何組肌肉無力並萎縮。

☐ Yes 是

☐ No 否

ii. Are there any other causes of the muscle weakness and damage?

肌肉的無力及損害是否由其他原因引致？

If "yes", please give detail.

如“是”，請提供詳情。

☐ Yes 是

☐ No 否

10. Was the diagnosis confirmed by a specialist in the relevant field?

此疾病是否經相關專科的註冊醫生證實確診？

☐ Yes 是

☐ No 否

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，請提供確診專科醫生之姓名，地址及專科。

11. Was the diagnosis confirmed by neuromuscular testing such as Electromyogram (EMG)?

是否經神經肌肉測試如肌電圖(EMG) 確診？

☐ Yes 是

☐ No 否

If "Yes", please state the name of the neuromuscular testing and provide the report of the testing.

如“是”，請列明該神經肌肉測試名稱及提供相關測試報告。

12. (a) If Insured is not bedridden, which of the following daily activities the Insured is NOT able to perform as a direct result of Type I Juvenile Spinal Amyotrophy? (please check the appropriate item)

如受保人不須永久臥床，受保人因一型青少年脊髓性肌肉萎縮症不能完成下列哪些日常生活活動？（請選擇適當的項目）

i. Getting in and out of a chair or bed without requiring any physical assistance.

在無需任何幫助的情況下，可自行上落床、坐椅及自椅子起立。

☐

ii. Ability to move from room to room without requiring any physical assistance.

在無需任何幫助的情況下，可自行由某一間房間移動至另一間房間。

☐

iii. The ability to voluntarily control bladder and bowel functions so as to maintain personal hygiene.

有控制膀胱及大腸功能的自發能力，以保持個人衛生。

☐

iv. Putting on and taking off all necessary items of clothing without requiring the assistance of another person.

在無需其他人士幫助的情況下，可自行穿著及除掉一切所需衣物。

☐

v. The ability to wash oneself in the bath or shower (including getting in or out of the bath or shower) or wash oneself by any other means.

可自行在浴缸或淋浴間進行沐浴或淋浴（包括進出浴缸或淋浴間）或使用其他方式洗澡的能力。

☐

vi. All tasks of getting food into the body once it has been prepared.

進食已預備好之食物的一切程序。

☐

(b) Is such inability expected to be permanent?

是否屬於永久性喪失該活動能力？

☐ Yes 是

☐ No 否

(c) Does the disease directly result in such inability?

是否由該疾病直接引致喪失該活動能力？

☐ Yes 是

☐ No 否

11. Please enclose copies of all reports including all reports, radiological procedures, MRI, CT scanning, electroencephalography, biopsy, laboratory evidence, other imaging studies, etc. and any relevant hospital reports that are available.
請提供所有報告，如放射性治療、磁力共振、電腦掃描、腦電圖、活體檢驗記錄、化驗報告及其他影像報告等，或任何有關的醫院報告。
12. 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。
13. 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案償個案之資料。

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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