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－CORONARY ARTERY SURGERY / MINIMALLY INVASIVE DIRECT CORONARY ARTERY BY-PASS
危疾－冠狀動脈手術 / 微創進行直接的冠狀動脈搭橋手術

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. 請提供受保人之所有及確定的診斷詳情。

2. Please describe the extent of the disease. 請描述該病之狀況。
   i. Which arteries are involved and what is the degree of narrowing (%) in respect of each involved artery? 請列出所有收窄了的冠狀動脈名稱及其血管腔收窄之程度 (百分比)。

   _____

   _____

   ii. Was the above confirmed by coronary arteriography? 上述是否經冠狀動脈血管造影檢查確定？ ☐ Yes 有 ☐ No 沒有

3. Surgical correction performed 進行之矯正手術
   Has the patient undergone surgical correction for the coronary artery disease?
   病人有否就其冠狀動脈疾病接受矯正手術？ ☐ Yes 有 ☐ No 沒有
   If yes, the type of surgical correction performed? 如有，進行了何種矯正手術？
   (a) Open chest coronary bypass grafting 開胸冠狀動脈搭橋 ☐ Yes 是 ☐ No 否
   If "yes", please state the number and sites of grafts inserted. 如"是"，請列出接枝之數量及植入之位置。

   _____

   (b) Minimally Invasive Direct Coronary Artery By-pass Surgery (Coronary artery by-pass surgery through a mini-thoracotomy)
   微創進行直接冠狀動脈搭橋手術（透過微型的開胸手術進行冠狀動脈搭橋手術） ☐ Yes 是 ☐ No 否
   (c) If none of the above 2 surgeries has been done, please state what other types of surgery was performed.
   如沒有進行上述兩項手術，請列出所進行之其他矯正手術。

   _____

   (d) Date and place of surgery 手術日期及地點
   ☐☐ ☐☐ ☐☐☐☐
   MM月 DD日 YYYY年
   The hospital where the surgery was performed 手術醫院 : _____
   (e) Was the surgery performed by a cardiologist? 手術是否由心臟專科醫生進行？ ☐ Yes 是 ☐ No 否
   Please give the Name and Address of the cardiologist if it is not the undersigned. 若非由填寫此表格之醫生進行，請提供心臟專科醫生之姓名及地址。

   _____

   If no surgical correction has been performed, please state the reason. 若未有進行矯正手術，原因為何？

   _____

4. Please enclose copies of all surgical reports, X-rays, CT scans, and any other imaging studies, laboratory evidence, angiograms, 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、及其他影像報告、化驗報告及血管造影術報告等，或任何有關的醫院報告。

5. 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。

6. 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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