AIA

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－END STAGE LUNG DISEASE / CHRONIC LUNG DISEASE
危疾－末期肺病 / 慢性肺病

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

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 provide full and exact details of the diagnosis: 請描述該疾病之狀況。

   i. Has the Insured's lung disease reached end-stage? 受保人現時之病況是否屬於末期肺病？ ☐ Yes 是 ☐ No 不是

   If "No", was it interstitial fibrosis? 如"不是"，是否屬於間質性肺纖維化肺病？ ☐ Yes 是 ☐ No 不是

   Date of onset 病發日期：

MM月	DD日	YYYY年

   ii. Is the insured now on medication? 受保人是否正接受藥物治療？ ☐ Yes 是 ☐ No 不是

   If "Yes", please provide the prescriptions. 如"是"，請提供藥物處方詳情。

   ._____

   iii. What is the FEV 1 test result of the Insured during the first second of a forced exhalation? 受保人在用力呼氣的第一秒期間的FEV1測驗結果如何？

   _____

   iv. What is the baseline arterial blood gas analysis result? 受保人的基準動脈血氧分析結果如何？

   _____

   v. Does the insured feel dyspnea at rest? 受保人於靜止時是否會感覺呼吸困難？ ☐ Yes 是 ☐ No 不是

   vi. Does the Insured require oxygen therapy? 受保人是否需要接受氧氣治療?

   ☐ Insured requires extensive & permanent oxygen therapy. 受保人需要廣泛及永久接受氧氣療法。

   ☐ Insured only requires intermittent oxygen therapy. 受保人只需要間歇性接受氧氣治療。

   ☐ Insured does not require oxygen therapy. 受保人不需要接受氧氣治療。

   If insured is currently under oxygen therapy, please give details such as start date, flow rate, concentration and frequency. 如受保人現正接受氧氣治療，請提供詳情（如：開始日期、流速、濃度及使用次數。）

   Start Date of Oxygen Therapy 開始接受氧氣治療之日期：

MM月	DD日	YYYY年

   Flow Rate 流速：_____

   Concentration 濃度：_____

   Frequency 每月使用次數：_____

3. 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.
   請提供所有報告包括X光檢查、電腦掃描、超聲波、其他影像、心電圖、手術及化驗報告等，或任何有關的醫院報告。

4. 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。

5. 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。

Policy Number 保單號碼 | | | | | | | | | | |

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。

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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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