

**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<br><div></div>    |                                                  |
| Name of Insured 受保人姓名<br><div></div> | ID Card / Passport No. 身分證 / 護照號碼<br><div></div> |

**CRITICAL ILLNESS – SURGERY TO AORTA / ENDOVASCULAR TREATMENTS OF AORTIC DISEASE OR AORTIC ANEURYSM****危疾 – 主動脈手術 / 主動脈疾病或主動脈瘤的血管介入治療****GENERAL INFORMATION 一般資料**

|                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                   |
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| <p>1. Are you the Insured's usual medical physician?<br/>閣下是否受保人慣常求診之醫生？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>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？<br/><div>MM月 DD日 YYYY年</div></p>                                          | <p>Details of "Yes" answers (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities).<br/>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。</p> |
| <p>2. When were you first consulted for this illness?<br/>受保人首次就有關疾病向閣下求診之日期。<br/><div>MM月 DD日 YYYY年</div></p> <p>What were the symptoms? 受保人之病徵。<br/><div></div></p> <p>How long had the symptoms been present? 該病徵約存在了多久？<br/><div></div></p>                                                |                                                                                                                                                                                                   |
| <p>3. Has the Insured previously suffered from this illness or any related conditions?<br/>受保人是否有同類之病史。 <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>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。<br/><div></div></p> |                                                                                                                                                                                                   |
| <p>4. On which date was the diagnosis made? 有關疾病之診斷是何時首次確認？<br/><div>MM月 DD日 YYYY年</div></p> <p>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？<br/><div>MM月 DD日 YYYY年</div></p>                                                                                       |                                                                                                                                                                                                   |
| <p>5. Is there anything in the Insured's family history which would have increased the risk of this illness?<br/>受保人之家族病史是否增加受保人患上此病之機會？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p>                                                                                      |                                                                                                                                                                                                   |
| <p>6. Is the Insured a smoker? 受保人是否吸煙人仕？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>If "Yes", what is his / her smoking habit? 若為吸煙人仕，他 / 她的吸煙習慣為何？<br/>Daily smoking amount 每日吸煙數量：_____ for how many years? 吸食年數：_____</p>                                         |                                                                                                                                                                                                   |

**OTHER / ADDITIONAL INFORMATION 其他 / 附加資料**

|                                                                                                                                                                                                |
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| <p>1. Please provide names, addresses and dates of doctors and hospitals which the Insured was referred and/or admitted to.<br/>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。<br/><div></div><br/><div></div></p> |
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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. Date of onset of the aortic condition 主動脈疾病之病發日期：

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MM月 DD日 YYYY年

Was the aortic disease confirmed by echocardiogram?

主動脈疾病是否經由心臟超音波檢查確診？

☐ Yes 是 ☐ No 否

If not confirmed by echocardiogram, by what other imaging tests was aortic disease confirmed? 如不是經由心臟超音波檢查確診，主動脈疾病是透過什麼影像檢查被確診？

Please state the date of the test and where it was performed. 請列出檢查進行之日期及地點。

Date 日期：

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MM月 DD日 YYYY年

Place 地點：

(Please supplement with relevant scan or imaging reports. 請提供相關的電腦掃描或影像報告以供參考。)

ii. Was any surgery performed? 有否施行手術？

☐ Yes 有 ☐ No 沒有

If "yes", please specify which aorta was operated and the location?

如“有”，請註明進行主動脈手術的是哪一條主動脈及進行手術的位置。

Was the surgery performed through thoracotomy or laparotomy?

手術是否經開胸或剖腹手術進行？

☐ Yes 是 ☐ No 否

Was the surgery performed through minimally Invasive or intra-arterial techniques?

手術是否經微創形式進行（即主動脈疾病的血管介入治療）？

☐ Yes 是 ☐ No 否

If "no" for the above 2 questions, please specify: 如以上兩項皆為“否”，請註明：

Date of the surgery to aorta 手術日期：

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MM月 DD日 YYYY年

The hospital where the surgery was performed 手術醫院：

Name of Surgeon 手術醫生：

The surgery was performed for correction / repair of: 進行之手術用作修補或矯正：

☐ Aortic anerysm 主動脈瘤

☐ Obstruction 主動脈阻塞

☐ Coartation / Narrowing 主動脈縮窄 / 狹窄

☐ Dissection 主動脈夾層分離

☐ Others (please specify): 其他（請註明）：

iii. For the case of Aortic Aneurysm, please specify the type of aneurysm: 就主動脈瘤個案而言，請註明動脈瘤之類別：

☐ Abdominal aortic anerysm 腹主動脈瘤

☐ Abdominal aortic dissection 腹主動脈夾層分離

☐ Thoracic aortic anerysm 胸主動脈瘤

☐ Thoracic aortic dissection 胸主動脈夾層分離

☐ Others (please specify): 其他（請註明）：

Has the Aorta been enlarged at least 50 mm in diameter?

主動脈的直徑有否增大至少50毫米？

☐ Yes 有 ☐ No 沒有

Was the diagnosis confirmed by a cardiologist or vascular surgeon?

該疾病是否由心臟專科或血管外科註冊醫生確定？

☐ Yes 是 ☐ No 否

Please give the Name and Address of the cardiologist or vascular surgeon if it is not the undersigned.

若非由填寫此表格之醫生確認，請提供心臟專科或血管外科註冊醫生之姓名及地址。

iv. Is there any known underlying causes or precipitating illness leading to the aortic condition? If so, please state any treatment history.

有沒有已知的原因或潛在的疾病引致主動脈疾病發生？如有，請列出過往之治療記錄。

3. Please enclose copies of all reports including surgical reports, X-rays, CT scans, other imaging studies, laboratory evidence, angiograms, etc, and any relevant hospital reports that are available.  
提供所有報告包括手術報告，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。
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案索償個案之資料。

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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