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－ALZHEIMER'S DISEASE / IRREVERSIBLE ORGANIC DEGENERATIVE BRAIN DISORDERS
危疾－亞爾茲默氏病 / 不可還原之器質腦退化性疾病

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

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. What is the age of onset of 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。

   _____

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

   i. Is there evidence of deterioration or loss of intellectual capacity or abnormal behaviour resulting in significant reduction in mental and social functioning requiring the continuous supervision of the Insured? 有否思考能力的退化、喪失或行為舉止失常，導致受保人之智力及社交活動能力嚴重降低，而令受保人須持續被照顧？ ☐ Yes 是 ☐ No 否

   If "yes", please describe the findings. 如"有"，請描述詳情。

   _____

   _____

   ii. Did the deterioration or loss of intellectual capacity or abnormal behaviour arose from neurosis, psychiatric illness and any drug or alcohol related organic disorder? 該次之思考能力退化、喪失或行為舉止失常是否因神經機能疾病、精神病及任何藥物、酒精引起的機能失調？ ☐ Yes 是 ☐ No 否否

5. Please enclose copies of questionnaires or test reports or any relevant hospital reports that are available. 請提供所有報告包括相關之問卷、檢查報告及醫院報告。

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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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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