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－MAJOR HEAD TRAUMA / MODERATELY SEVERE BRAIN DAMAGE / SURGERY FOR SUBDURAL HAEMATOMA
危疾－嚴重頭部創傷 / 中度嚴重腦部損傷 / 腦硬膜下血腫手術

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. Date of the head injury 頭部受傷日期

   Cause of injury 受傷原因

   _____

   The doctor or medical facility who first attended the patient 第一次求診之醫生或醫療機構名稱

   _____

   Please describe the degree of the injury. 請形容傷勢。

   _____

   When were you first consulted for this injury? 受保人首次就有關意外向閣下求診之日期。

   ☐☐ MM月 ☐☐ DD日 ☐☐☐☐ YYYY年

3. 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：_____

4. 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。

5. Was the Injury induced from or affected by any of the followings which might have contributed to the accident?
(Please check the appropriate item(s) 頭部創傷是否因下列原因導致或引發？（請選擇適當的項目）

   ☐ Physical deflects / Congenital anomaly 身體殘陷 / 先天性毛病
   ☐ Degenerative changes 退化
   ☐ Unfavourable past medical history 過往病史/疾病
   ☐ Alcohol or drugs 酒精或藥物

   If "Yes", please give details of the checked item(s). 如"是"，請提供有關項目的詳情。

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。

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6. Investigation done. 檢查詳情：

Dates 日期	Procedures 檢查項目 / 名稱	Results 結果

Note : Please enclose copies of all reports, including biopsy reports, cytology reports, X-rays, CT scans, MRI and other imaging studies, laboratory tests, surgical report, etc. and any relevant hospital reports that are available.
備註：請提供所有報告包括活體檢視記錄、細胞分析報告、X光檢查、電腦掃描、磁力共震、其他影像、化驗及手術報告等，或任何有關的醫院報告。

7. Details of treatment rendered. 治療詳情：

i. Has the patient undergone any surgery due to head injury?
病人有否就頭部創傷接受任何手術？ ☐ Yes 有 ☐ No 沒有

If yes, the type of surgery performed? 如有，進行了何種手術？

(a) Burr Hole Surgery to the head 於頭部鑽孔手術 ☐ Yes 是 ☐ No 否

If "yes", please state the purpose of the surgery. 如"是"，請列明進行鑽孔手術的目的?

_____

(b) Others, please specify. 其他，請註明手術名稱。

_____

Date of the surgery 手術日期：

MM月	DD日	YYYY年

The hospital where the surgery was performed 手術醫院：_____

Name of Surgeon 手術醫生：_____.

Was the surgery certified to be medically necessary by a neurologist?
手術是否由腦神經專科醫生證實為醫療所需？ ☐ Yes 是 ☐ No 否

Please give the Name and Address of the neurologist if it is not the undersigned. 若非由填寫此表格之醫生確認，請提供腦神經專科醫生之姓名及地址。

_____

ii. If no surgery was done, please state what other treatment has been rendered for the insured. 如沒有進行手術，請列出受保人曾接受的其他治療項目。

_____

8. Which of the following daily activities is he/she NOT able to perform as a direct result of the trauma. (Please check the appropriate items.)
受保人因嚴重頭部創傷而不能完成下列哪些日常生活活動？（請選擇適當的項目。）

☐ 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。

☐ 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。

☐ 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。

☐ 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。

☐ 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

☐ 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。

How long have such inability been medically documented? 根據醫學證據，上列的活動能力喪失了多久？

_____

Is such inability expected to be permanent? 喪失的活動能力是否屬於永久性？ ☐ Yes 是 ☐ No 否

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。

_____

9. Prognosis. 病情進展。

10. 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。

11. 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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