

**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 – SYSTEMIC LUPUS ERYTHEMATOSUS (S.L.E.) WITH LUPUS NEPHRITIS / LESS SEVERE SYSTEMIC LUPUS ERYTHEMATOSUS****危疾 – 系統性紅斑狼瘡併發狼瘡性腎炎 / 次級嚴重系統性紅斑狼瘡****GENERAL INFORMATION 一般資料**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <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. Was the diagnosis of SLE formally confirmed?<br/>系統性紅斑狼瘡之診斷有否被確認？ <input type="checkbox"/> Yes 有 <input type="checkbox"/> No 沒有</p> <p>On which date was the diagnosis made and by whom? 有關疾病之診斷是由誰及於何時首次確認？<br/>On ( / / ) MM/DD/YYYY by Dr. _____<br/>於 _____ 年 _____ 月 _____ 日由 _____ 醫生首次確認</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>Was the diagnosis confirmed by a rheumatologist or immunologist?<br/>是否經風濕科或免疫系統專科註冊醫生確診？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>Please give Name and Address of the rheumatologist or immunologist confirming the diagnosis if it is not the undersigned. 若非由填寫此表格之醫生確診，請提供確診之風濕科或免疫系統專科醫生之姓名及地址。<br/><div></div></p> |                                                                                                                                                                                                   |

**DETAILS OF THE INSURED'S ILLNESS 受保人病況之詳情**

## 5. Results &amp; dates of following laboratory tests (Please provide copy of test results):

接受下列化驗的日期及其結果 (請提供報告副本以供參考。)

| Name of Laboratory<br>化驗項目          | Test Results<br>化驗結果 | Dates (MM/DD/YYYY)<br>日期 (月/日/年) |
|-------------------------------------|----------------------|----------------------------------|
| Anti-Nuclear Antibodies<br>抗核抗體     |                      |                                  |
| L.E. Cells<br>狼瘡細胞                  |                      |                                  |
| Anti-Sm<br>抗平滑肌抗體                   |                      |                                  |
| Anti-DNA<br>抗脫氧核糖核酸抗體               |                      |                                  |
| Creatinine Clearance Rate<br>呈肌酐清除率 |                      |                                  |
| Past record<br>過去記錄                 |                      |                                  |
| Latest record<br>最近記錄               |                      |                                  |

## 6. Results of other investigations, e.g. biopsy, renal function test, etc. (Please provide copy of test results.)

其他檢查結果, 如:活體檢視記錄、肝功化驗等 (請提供報告副本以供參考。)

## 7. Please confirm which of the following clinical manifestations is exhibited by the insured:

請確認受保人之狀況是否呈現出下列病徵:

|                                                       | Yes<br>是                 | No<br>不是                 | If "yes", please supplement: 如“是”, 請提供附加資料:                                                                                                                                                                                          |
|-------------------------------------------------------|--------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| i. Arthritis 關節炎                                      | <input type="checkbox"/> | <input type="checkbox"/> | a. Erosive Arthritis? 屬磨損性關節炎? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 不是<br>b. No. of Joints involved 受影響的關節數目: _____                                                                                            |
| ii. Serositis 漿膜炎                                     | <input type="checkbox"/> | <input type="checkbox"/> | a. Type of Serositis 漿膜炎類別:<br><input type="checkbox"/> Pleuritis 胸膜炎 <input type="checkbox"/> Pericarditis 心包炎<br><input type="checkbox"/> Others (please specify) 其他 (請註明): _____                                                  |
| iii. Renal disorder 腎功能障礙                             | <input type="checkbox"/> | <input type="checkbox"/> | a. Persistent proteinuria > 0.5 g per day?<br>持續每天尿蛋白有否超過0.5克? <input type="checkbox"/> Yes 有 <input type="checkbox"/> No 沒有<br>b. Cellular casts noted?<br>尿液檢查呈細胞圓柱? <input type="checkbox"/> Yes 有 <input type="checkbox"/> No 沒有 |
| iv. Malar rash 頰疹                                     | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                                      |
| v. Discoid rash 盤狀疹                                   | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                                      |
| vi. Photosensitivity 對光敏感                             | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                                      |
| vii. Oral ulcers 口腔潰瘍                                 | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                                      |
| viii. Haemolytic anemia 溶血性貧血                         | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                                      |
| ix. Leukopenia 白血球減少 [ $<4,000/\mu\text{L}$ ]         | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                                      |
| x. Lymphopenia 淋巴細胞減少 [ $<1,500/\mu\text{L}$ ]        | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                                      |
| xi. Thrombocytopenia 血小板減少 [ $<100,000/\mu\text{L}$ ] | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                                      |
| xii. Neurological disorder 神經障礙                       | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                                      |
| xiii. Others (please specify)<br>其他 (請註明): _____      |                          |                          |                                                                                                                                                                                                                                      |

## 8. Has SLE with Lupus Nephritis been definitely diagnosed?

系統性紅斑狼瘡併發狼瘡性腎炎之診斷有否被確認?

☐ Yes 有 ☐ No 沒有

If "yes", what is the class of the Insured's Lupus Nephritis according to the Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS) classification of Lupus Nephritis (2003)?

如“有”, 根據國際腎臟協會/腎臟病理協會的狼瘡性腎炎分類, 受保人的狼瘡性腎炎屬於何種分類?

- ☐ Class I – Minimal mesangial lupus nephritis 第I級 – 微小系膜狼瘡性腎炎
- ☐ Class II – Mesangial proliferative lupus nephritis 第II級 – 系膜增生性狼瘡性腎炎
- ☐ Class III – Focal lupus nephritis 第III級 – 病灶性狼瘡性腎炎
- ☐ Class IV – Diffuse segmental (IV-S) or global (IV-G) lupus nephritis
- ☐ IV 級 – 彌漫性節段性 (IV-S 級) 狼瘡性腎炎或全球性 (IV-G 級) 狼瘡性腎炎
- ☐ Class V – Membranous lupus nephritis 第V級 – 膜性狼瘡性腎炎
- ☐ Class VI – Advanced sclerosing lupus nephritis 第VI級 – 高度硬化性狼瘡性腎炎

9. If Insured is not bedridden, which of the following daily activities is he/she NOT able to perform as a direct result of SLE with Lupus Nephritis? (please check the appropriate item)

如受保人不須永久臥床，他/她因系統性紅斑狼瘡併發狼瘡性腎炎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 has 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

10. Please describe any other cardiac, central nervous stem or renal impairment? 請描述受保人的心臟、中樞神經或腎臟之損壞狀況。

11. How long has the condition been medically documented? 上述病症約存在了多久？

12. Details of treatment rendered. 治療詳情：

Was there any surgery performed? 受保人有沒有接受手術治療？

☐ Yes 有 ☐ No 沒有

If "Yes", please provide details of surgical procedure(s). 如“有”，請提供曾接受之手術詳情。

13. Prognosis. 病情進展：

14. 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。

15. 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

16. Please provide details of the insured's habits in relation to smoking cigarettes (including no. of sticks smoked per day).

請提供受保人的吸煙習慣之詳情包括每日之吸煙數量。

17. Is the insured's HIV (Human Immunodeficiency Virus) positive? If so, please provide details including the date of diagnosis.

受保人之感染人體免疫力缺乏病毒測試是否呈陽性反應？如是，請提供詳情包括診斷日期。

18. 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.  
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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I / We acknowledge and consent to the transfer of my / our personal data to parties within or outside Hong Kong (for policy(ies) / pension scheme(s) issued in Hong Kong) or Macau (for policy(ies) / pension scheme(s) issued in Macau), as the case may be, for the purposes as set out in the PICS.

The latest version of the PICS which complies with the relevant rules and regulations is / are available for download from the above website and upon request.

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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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