

**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

FEMALE PRODUCT – URINARY INCONTINENCE REQUIRING SURGICAL REPAIR**女性保險 – 需要手術治療之小便失禁****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	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。											
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. Other physicians or medical facilities the patient has consulted for this condition. 受保人曾經就診之其他醫生或醫療機構資料。 <table border="1"><thead><tr><th>Name of physician / facility 醫生姓名或醫院名稱</th><th>Address 地址</th><th>Date of consultation / confinement period (MM/DD/YYYY) 求診日期 / 住院時段 (月/日/年)</th></tr></thead><tbody><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr></tbody></table>		Name of physician / facility 醫生姓名或醫院名稱	Address 地址	Date of consultation / confinement period (MM/DD/YYYY) 求診日期 / 住院時段 (月/日/年)								
Name of physician / facility 醫生姓名或醫院名稱	Address 地址	Date of consultation / confinement period (MM/DD/YYYY) 求診日期 / 住院時段 (月/日/年)										

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

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

8. Results & dates of laboratory tests (Please provide copy of test results):

接受化驗的日期及其結果（請提供報告副本以供參考。）

Name of Laboratory 化驗項目	Test Results 化驗結果	Dates (MM/DD/YYYY) 日期 (月/日/年)

9. 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。）

10. Details of treatment rendered 治療詳情：

Is surgery necessary for the Insured's current condition? 受保人現時之狀況是否需要手術治療？ ☐ Yes 是 ☐ No 否

If "Yes", please provide details of surgical procedure(s). 如“是”，請提供手術詳情。

13. Present condition of the insured 受保人現時之病況。

12. Prognosis 病情進展：

13. 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。

14. 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。

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。

PERSONAL DATA COLLECTION AND USE

I / We confirm that I / we have read, understood and agreed to the Personal Information Collection Statement(s) of my / our policy issuer(s) and / or pension scheme provider(s), i.e. AIA International Limited (Hong Kong Branch), AIA International Limited (Macau Branch), AIA Company Limited and / or AIA Everest Life Company Limited, where applicable, (the "PICS") which is available for download: <https://www.aia.com.hk/en/privacy-statement-main>.

I / We declare and agree that any personal data and other information relating to me / us or my / our policy(ies), account(s) or investments contained in this application or collected, obtained, compiled or held by my / our policy issuer(s) and / or pension scheme provider(s) by any means from time to time may be collected and utilized in accordance with the PICS.

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.

個人資料收集及使用

我 / 我們確認我 / 我們已閱讀、明白及同意我 / 我們的保單續發人及 / 或退休金計劃服務提供者（即友邦（國際）有限公司（香港分行）、友邦（國際）有限公司（澳門分行）、友邦保險有限公司及 / 或友邦雋峰人壽有限公司（如適用））的個人資料收集聲明（「該聲明」），該聲明可在以下網址下載

<https://www.aia.com.hk/zh-hk/privacy-statement-main>。

我 / 我們聲明及同意在本申請所載或我 / 我們的保單續發人及 / 或退休金計劃服務提供者不時以任何方法收集、獲得、編製或持有的任何個人資料及關於我 / 我們的保單、帳戶或投資的其他資料，可根據該聲明收集及使用。

我 / 我們知悉及同意就該聲明所述目的轉移我 / 我們的個人資料至香港境外 / 境內（如保單 / 退休金計劃在香港續發）或澳門境外 / 境內（如保單 / 退休金計劃在澳門續發）（視乎情況而定）予該聲明所載的資料承讓人。

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



Download our AIA+ mobile app to manage your policy!
下載 AIA+ 手機應用程式以便輕鬆管理您的保單！

"AIA" shall refer to AIA International Limited (Incorporated in Bermuda with limited liability), AIA Company Limited (Incorporated in Hong Kong with limited liability), as the case may be, depending on the issuing company of the relevant insurance policies this form is subject to. 「AIA」或「友邦」指友邦保險（國際）有限公司（於百慕達註冊成立之有限公司），友邦保險有限公司（於香港註冊成立之有限公司）（視情況而定），具體取決於此信件相關表格的簽發公司。