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

FEMALE PRODUCT疾－Mother & Child Benefits (Complications of Pregnancy / Congenital Anomalies / Severe Child Disease)

女性保險疾－母子保障惠益 (妊娠期併發症 / 先天性疾病 /嚴重兒童疾病)

Section 1: GENERAL INFORMATION 第一部份：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 did the insured first consult you for her pregnancy condition?
   受保人首次因懷孕向閣下求診之日期。
   ☐☐ MM月 ☐☐ DD日 ☐☐☐☐ YYYY年
   When was the date of conception? 受孕日期始於何時？
   ☐☐ MM月 ☐☐ DD日 ☐☐☐☐ YYYY年
   When was pregnancy first confirmed? 懷孕於何時被確認？
   ☐☐ MM月 ☐☐ DD日 ☐☐☐☐ YYYY年

3. When was / would be the date of delivery? 嬰兒於（預計）在何時出生？
   ☐☐ MM月 ☐☐ DD日 ☐☐☐☐ YYYY年

4. When did the claimed condition confirmed and by whom? 索償之狀況於何時被確認及由誰確認？
   Confirmed by _____ on (/ /) MM/DD/YYYY
   於 (/ /) 月/日/年被 _____ 醫生確認

5. Is there anything in the Insured's family history which would have increased the risk of the above pregnancy related problem?
   受保人之家族病史是否增加受保人罹患上述與懷孕有關之問題的機會？ ☐ Yes 是 ☐ No 否
   If "Yes", please explain in details. 如"是"，請闡釋：
   _____
   _____

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。

Name of physician / facility 醫生 / 機構名稱	Address 地址	Date of consultation / confinement period 求診日期 / 住院時段

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。

Policy Number 保單號碼 | | | | | | | | | | |

Section 2－To be completed for Complications of Pregnancy
第二部份－如申請索償類別為『妊娠期併發症』適用

1. Claimed Condition 索償狀況
   - ☐ Disseminated Intravascular Coagulation (DIC) 瀰漫性血管內凝血
   - ☐ Ectopic Pregnancy 宮外孕
   - ☐ Hydatidiform Mole 葡萄胎
   - ☐ Others, please specify: 其他，請註明：_____

2. Please provide full and exact details of the diagnosis. 請提供該病之狀況及其診斷結果。

3. Please describe the extent of the condition. 請描述該病之狀況。
   i. Was the claimed condition pregnancy related? 索償之狀況是否與懷孕有關？ ☐ Yes 是 ☐ No 不是
   If "Yes", what were the symptoms and since when were the symptoms first appeared? 如"是", 有什麼徵狀及有關徵狀始於何時發生？
   _____
   Through what examination / laboratory test was the claimed condition confirmed? (Please provide a copy of the test report.)
   由哪種檢查 / 化驗報告確認索償之狀況？（請提供有關報告。）
   _____
   _____
   ii. If claimed for "Disseminated Intravascular Coagulation (DIC)", 如申請索償狀況為「瀰漫性血管內凝血」。
   a. Was there excessive fibrin formation and fibrinolysis has caused the depletion of coagulation proteins and platelets?
   是否有大量纖維蛋白形成及纖維蛋溶解而導致凝血蛋白及血小板過度消耗？ ☐ Yes 是 ☐ No 不是
   b. Was there life threatening haemorrhage from multiple sites?
   是否有多個部位大量出血而導致性命受到威脅？ ☐ Yes 是 ☐ No 不是
   iii. If claimed for "Ectopic Pregnancy", 如申請索償狀況為「宮外孕」,
   a. Where did the implantation of fertilized ovum occur? 受精卵在哪裏發育？
   _____
   b. 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"，請提供手術詳情。
   _____
   iv. If claimed for "Hydatidiform Mole", 如申請索償狀況為「葡萄胎」。
   a. Was it a gestational trophoblastic disease with abnormal hyperplasia of trophoblasts?
   是否有妊娠滋養層疾病形成不正常的滋養層增生？ ☐ Yes 有 ☐ No 沒有
   b. Was it resulted in uterus being filled with abnormal vesicular villi tissue with no sign of a foetus?
   是否導致子宮被不正常的水泡性絨毛組織充塞及沒有胎兒的徵狀？ ☐ Yes 是 ☐ No 不是
   v. If claimed for "Others", 如申請索償狀況為「其他」。
   a. Please describe the claimed condition in details. 請詳細形容索償狀況。
   _____
   b. What were the symptoms and since when were the symptoms first appeared? 有什麼徵狀及有關徵狀始於何時發生?
   _____
   c. 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"，請提供手術詳情。
   _____
   If "No", please provide treatment details. 如"沒有"，請提供治療詳情。
   _____

4. Please enclose copies of all reports including radiological reports, CT scanning, MRI and other imaging studies, laboratory tests and any relevant hospital reports that are available.
   請提供所有報告包括影像報告，電腦掃描，磁力共震，超聲波及其他影像，化驗報告，及任何有關的醫院報告。

Policy Number 保單號碼 | | | | | | | | | | |

Section 3－To be completed for Congenital Anomalies
第三部份－如申請索償類別為『先天性疾病』適用

1. Claimed Condition 索償狀況
   - ☐ Down's Syndrome 唐氏綜合症
   - ☐ Spina Bifida 脊柱裂
   - ☐ Tetralogy of Fallot 法樂氏四聯症
   - ☐ Oesophageal Atresia & Tracheoesophageal Fistula 食道閉鎖及食道氣管瘺
   - ☐ Hydrocephalus 腦積水
   - ☐ Neonatal Death 新生嬰兒夭折
   - ☐ Others, please specify: 其他，請註明：_____

2. Please provide full and exact details of the diagnosis. 請提供該病之狀況及其診斷結果。

3. Please describe the extent of the condition. 請描述該病之狀況。
   i. What were the symptoms and since when were the symptoms first appeared? 如“是”，有什麼徵狀及有關徵狀始於何時發生?

   _____

   Through what examinations / laboratory tests were the claimed condition confirmed? (Please provide copies of all test reports.)
   由哪種檢查 / 化驗報告確認索償之狀況？（請提供所有有關報告。）

   _____

   _____

   ii. If claimed for "Down's Syndrome", 如申請索償狀況為「唐氏綜合症」，
      a. Is there an extra chromosome 21? 第二十一對染色體是否異常地多了一個常染色體？ ☐ Yes 是 ☐ No 不是
      b. Does the patient exhibit the below symptoms? 患者是否有下列徵兆？
         - muscular hypotonicity 有肌張力減退 ☐ Yes 是 ☐ No 否
         - microcephaly / brachycephaly 小頭畸形 / 短頭畸形 ☐ Yes 是 ☐ No 否
         - flattened occiput 枕骨扁平 ☐ Yes 是 ☐ No 否
      c. What is the nature and extent of retardation of physical and mental development? 體格及智力發育遲緩的性質及程度。

      _____

   iii. If claimed for "Spina Bifida", 如申請索償狀況為「脊柱裂」，
      a. Does the foetus exhibit the following symptoms? 胎兒是否有下列徵狀？
         - Varying degrees of paralysis 不同程度的癱瘓 ☐ Yes 有 ☐ No 沒有
         - Loss of sensation in the lower limbs 下肢失去知覺 ☐ Yes 有 ☐ No 沒有
         - Difficulty of bowel and bladder control 難以控制膀胱及大腸功能 ☐ Yes 有 ☐ No 沒有
         - Hydrocephalus 腦積水 ☐ Yes 有 ☐ No 沒有
         - Learning disabilities 學習障礙 ☐ Yes 有 ☐ No 沒有

      If any of the above answers is "Yes", please describe in details. 如以上任何一項為“是”，請詳細描述。

      _____

      _____

   iv. If claimed for "Tetralogy of Fallot", 如申請索償狀況為「法樂氏四聯症」，
      a. Is there severe or total right ventricular outflow tract obstruction? Please elaborate. 右心室外流之血管是否有嚴重或完全阻塞之情況? 請詳述。

      _____

      b. Is there ventricular septal defect allowing right ventricular unoxygenated blood to bypass the pulmonary artery and enter the aorta directly? Please elaborate. 是否有心室間隔缺損而導致靜脈血不經過肺動脈而直接進入主動脈之情況?請詳述。

      _____

      c. Please provide dates and details of any operations performed. 請提供接受手術之日期及詳情。

      _____

v. If claimed for “Oesophageal Atresia & Tracheoesophageal Fistula”, 如申請索償狀況為「食道閉鎖及食道氣管瘺」，

a. Is it a form of congenital malformation in which the oesophageal terminates in a blind sac?
是否因先天性食道發育畸形而致食道止於一密閉氣囊？ ☐ Yes 是 ☐ No 不是

b. Is it a form of congenital malformation in which the oesophageal forms a fistula communicating with the trachea?
是否因先天性食道發育畸形而致食道形成一瘺管與氣管相通？ ☐ Yes 是 ☐ No 不是

c. 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”，請提供手術詳情。

_____

_____

vi. If claimed for “Hydrocephalus”, 如申請索償狀況為「腦積水」,

a. Was it resulted in abnormal increase in the amount of cerebrospinal fluid within the ventricles of the brain?
是否導致腦室內的腦脊髓液不正常地增加？ ☐ Yes 是 ☐ No 不是

b. Was the child diagnosed of marked neurological deficits?
小童有否被證實患有明顯的神經缺損？ ☐ Yes 有 ☐ No 沒有

If “Yes”, please describe the neurological deficits in details. 如“有”，請詳細描述神經缺損的情況。

_____

_____

c. 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”，請提供手術詳情。

_____

_____

vii. f claimed for “Neonatal Death”, 如申請索償狀況為「新生嬰兒夭折」，

a. Date of Delivery of the baby 嬰兒出生日期

☐☐ ☐☐ ☐☐☐☐
MM月 DD日 YYYY年

b. Date of Death of the baby 嬰兒死亡日期

☐☐ ☐☐ ☐☐☐☐
MM月 DD日 YYYY年

c. Cause of death of the baby 嬰兒死亡原因

_____

viii. If claimed for “Others”, 如申請索償狀況為「其他」1

a. Please describe the claimed condition in details. 請詳細形容索償狀況。

_____

b. What were the symptoms and since when was the symptoms first appeared? 有什麼徵狀及有關徵狀始於何時發生?

_____

c. 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”，請提供手術詳情。

_____

_____

If “No”, please provide treatment details. 如“沒有”，請提供治療詳情。

_____

_____

4. Please enclose copies of all reports including prenatal testing, radiological reports, cardiac catheterization, angiocardiography, echocardiography, CT scanning, MRI, ultrasound and other imaging studies, laboratory tests and any relevant hospital reports that are available.
請提供所有報告包括產前檢查，影像報告，心導管檢查，心血管造影術，超聲心動圖，電腦掃描，磁力共震，超聲波及其他影像，化驗報告，及任何有關的醫院報告。

Policy Number 保單號碼 | | | | | | | | | | |

Section 4－To be completed for Severe Child Disease
第四部份－如申請索償類別為『嚴重兒童疾病』適用

1. Claimed Condition 索償狀況
   - ☐ Severe Asthma 嚴重哮喘
   - ☐ Leukaemia 白血病
   - ☐ Bone Marrow Transplant 骨髓移植
   - ☐ Brain Surgery 腦部手術
   - ☐ Tuberculous Meningitis 結核性腦膜炎
   - ☐ Others, please specify: 其他，請註明：_____

2. Please provide full and exact details of the diagnosis. 請提供該病之狀況及其診斷結果。

3. Please describe the extent of the condition. 請描述該病之狀況。
   i. What were the symptoms and since when were the symptoms first appeared? 有什麼徵狀及有關徵狀始於何時發生？

   _____

   Through what examinations / laboratory tests were the claimed condition confirmed? (Please provide copies of all test reports.)
   由哪種檢查 / 化驗報告確認索償之狀況? (請提供所有有關報告。)

   _____

   _____

   ii 1If claimed for “Severe Asthma”, 如申請索償狀況為「嚴重哮喘」，
   a. Was continuous daily usage of oral corticosteroids required to control the child’s asthma?
   是否需要持續性每日服用口服類固醇激素以控制小童的哮喘？ ☐ Yes 是 ☐ No 不是

   If “Yes”, since when was oral corticosteroids recommended? 如“是”，服用口服類固醇激素始於何時？

   _____

   Was it recommended by a consultant paediatrician? 是否經兒科顧問醫生處方？ ☐ Yes 是 ☐ No 不是

   Please give Name and Address of the paediatrician if it is not the undersigned.
   若非由填寫此表格之醫生確診，請提供兒科顧問醫生之姓名及地址。

   _____

   b. Was there presence of chest deformities resulting from chronic hyperinflation?
   是否出現因肺部長期過度膨脹而造成之胸部變形？ ☐ Yes 是 ☐ No 不是

   Was it confirmed by a consultant paediatrician? 是否經兒科顧問醫生確診？ ☐ Yes 是 ☐ No 不是

   c. Was there significant retardation of growth and development of the child?
   小童是否有明顯生長與發育遲緩？ ☐ Yes 是 ☐ No 不是

   Was it documented by failing percentiles on growth charts within a six (6) month period? (Please provide copy of health record for reference.) 是否以六(6)個月內生長曲線百份比下跌證實生長與發育遲緩? (請提供健康檢查報告以供參考。) ☐ Yes 是 ☐ No 不是

   d. Has the child ever hospitalized for exacerbations of asthma during the past few years?
   小童有否於過去幾年內因哮喘發作而需留院治療？ ☐ Yes 有 ☐ No 沒有

   If “Yes”, please provide all hospitalization details. 如“有”，請提供所有住院詳情。

Name of hospital 醫院名稱	Address 地址	Confinement period 住院時段

   Was it recommended by a consultant paediatrician? 是否經兒科顧問醫生建議？ ☐ Yes 是 ☐ No 不是

   e. Was there history of status asthmaticus? 是否曾發生哮喘持續狀態？ ☐ Yes 是 ☐ No 不是

   If “Yes”, when was it and how long has it persisted? 如“是，何時發生及持續時段？

   _____

iii. If claimed for “Leukaemia”, 如申請索償狀況為「白血病」，

a. Which of the followings was diagnosed? 下列哪一項被確診？

☐ Acute Myeloid Leukaemia 急性骨髓白血病

☐ Chronic Myeloid Leukaemia 慢性骨髓白血病

☐ Acute Lymphocytic Leukaemia 急性淋巴細胞性白血病

b. Was the diagnosis confirmed by a consultant haematologist or pathologist?
是否經血液病顧問醫生或病理學家確診？ ☐ Yes 是 ☐ No 不是

Please give Name and Address of the haematologist or pathologist if it is not the undersigned.
若非由填寫此表格之醫生確診，請提供血液病顧問醫生或病理學家之姓名及地址。

_____

c. Was chemotherapy required? 是否需要接受化學療法？ ☐ Yes 是 ☐ No 不是

If “Yes”, please give treatment details. 如“是”，請提供治療詳情。

_____

d. Was bone marrow transplant required? 是否需要接受骨髓移植治療？ ☐ Yes 是 ☐ No 不是

If “Yes”, please give treatment details. 如“是”，請提供治療詳情。

_____

iv. If claimed for “Bone Marrow Transplant”, 如申請索償狀況為「骨髓移植」，

a. Date of the transplant. 進行移植手術之日期。

☐☐ ☐☐ ☐☐☐☐
MM月 DD日 YYYY年

b. Place where the transplant was done 進行器官移植的地方

_____

c. Was bone marrow transplant preceded by total bone marrow ablation?
人體骨髓移植前有否先進行全身骨髓消融？ ☐ Yes 有 ☐ No 沒有

d. What caused the need for the organ transplant? 需要接受器官移植之原因。

_____

v. If claimed for “Brain Surgery”, 如申請索償狀況為「腦部手術」，

a. Date of Surgery 進行手術之日期。

☐☐ ☐☐ ☐☐☐☐
MM月 DD日 YYYY年

b. Name and nature of Surgical Procedure 手術名稱及性質

_____

c. Was the surgery recommended by a neurologist? 是否經腦神經專科醫生建議進行手術？ ☐ Yes 是 ☐ No 否

Please give Name and Address of the neurologist if it is not the undersigned. 若非由填寫此表格之醫生建議進行手術，請提供該腦神經專科醫生之姓名及地址。

_____

d What caused the need for the brain surgery? Please give details. 需要接受腦部手術之原因。 請提供詳情。

_____

vi. If claimed for "Tuberculous Meningitis", 如申請索償狀況為「結核性腦膜炎」，

a. Etiology. 病因為何？

_____

_____

b. Is there any significant and serious neurological deficit resulted?
有沒有因結核性腦膜炎導致任何嚴重的神經虧損？ ☐ Yes 有 ☐ No 沒有

If "Yes", please give details of the deficit (including cognitive and physical impairments) and state how long it has been documented.
如"有"，請提供神經虧損之狀況（包括認知損害及身體受損方面）及該狀況約存在了多久？

_____

_____

Is the neurological deficit expected to be temporary or permanent? 該神經虧損估計是屬暫時性還是永久性？
☐ Temporary 暫時性 ☐ Permanent 永久性

c. If Insured is not bedridden, which of the following daily activities the Insured is NOT able to perform as a direct result of Tuberculous Meningitis (please check the appropriate item) 如受保人不須永久臥床，受保人因結核性腦膜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。

d. Whether HIV Infection is present in the patient 病人有否感染人體免疫力缺乏病毒 (HIV)？ ☐ Yes 有 ☐ No 沒有

If yes, please give details. 如有，請提供詳情。

_____

_____

vii. If claimed for "Others", 如申請索償狀況為「其他」，

a. Please describe the claimed condition in details. 請詳細形容索償狀況。

_____

_____

b. What were the symptoms and since when was the symptoms first appeared? 有什麼徵狀及有關徵狀始於何時發生?

_____

_____

c. 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"，請提供手術詳情。

_____

_____

If "No", please provide treatment details. 如"沒有"，請提供治療詳情。

_____

_____

4. Please enclose copies of all reports including radiological reports, CT scanning, MRI, ultrasound and other imaging studies, laboratory tests and any relevant hospital reports that are available.
請提供所有報告包括影像報告，電腦掃描，磁力共震，超聲波及其他影像，化驗報告，及任何有關的醫院報告。

Policy Number 保單號碼 | | | | | | | | | | |

Section 5: OTHER INFORMATION 第五部份：其他資料

1. Present condition of the claimed diagnosis. 索償診斷的目前病況。

2. Prognosis. 病情進展：

3. 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。

4. 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。

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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.

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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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