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－FACIAL RECONSTRUCTIVE SURGERY FOR INJURY DUE TO ACCIDENT
## 危疾－意外受傷所需的面容重建手術

**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. 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. 請提供該病之狀況及其診斷結果。

2. Please describe the extent of the facial injury. 請描述該面部受傷之狀況。
   i. Date of Accident 意外日期：
   MM月 DD日 YYYY年
   ii. Location of the injured facial area 面部受傷位置：_____
   iii. Has the shape and appearance of the facial structures become defective, missing or damaged due to the accident?
   意外有否導致面部構造不完整、缺掉或受損？ ☐ Yes 有 ☐ No 沒有
   If "yes", please describe the condition in details. 如"有"，請詳細描述其狀況。
   _____
   _____
   iv. What was the cause of the facial injury? 該面部受傷是因何引致？
   ☐ Illness 疾病：_____
   ☐ Accidental Injury 意外受傷：_____
   ☐ Self-inflicted Injury 自致的受傷：_____
   ☐ Others 其他：_____

3. Details of treatment rendered 治療詳情:
   i. 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
   _____
   ii. Was hospitalization required due to the facial injury? 有否因為面部受傷而需要接受住院治療？ ☐ Yes 有 ☐ No 沒有
   If "yes", please state the period(s) of hospital confinement(s). 如"有"，請列出住院時段。
   From 由 MM月 DD日 YYYY年 To 至 MM月 DD日 YYYY年
   Name of Hospital 醫院名稱：_____
   Name of Attending doctor 主診醫生名稱：_____
   iii. Has the patient undergone any plastic or reconstructive surgery due to the facial injury?
   病人有否就面部受傷接受任何整形或重建手術？ ☐ Yes 有 ☐ No 沒有
   If "yes", please specify the name of the procedure done. 如"有"，請列出曾進行的手術程序名稱 。
   _____
   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 plastic or reconstructive surgery certified to be medically necessary by the Surgeon?
   整形或重建手術是否由手術醫生證實為醫療所需？ ☐ Yes 是 ☐ No 否
   Was the surgery performed due to any of the following reasons? (Please check the appropriate item(s)).
   是否因下列原因進行手術？（請選擇適當的項目。）
   ☐ Cosmetic 整容原因
   ☐ Isolated nasal fractures 獨立的鼻骨折斷
   ☐ Isolated dental restorations 獨立的牙齒修復
   ☐ Isolated skin wounds 獨立的皮膚傷口
   ☐ Others (please specify)：其他 (請註明)：_____
   iv. If no hospitalization was required and no surgery was done, please state what other treatment has been rendered for the insured.
   如不需住院或沒有進行手術，請列出受保人曾接受的其他治療項目。
   _____

4. Please enclose copies of all surgical reports, X-rays, CT scans, and any other imaging studies, laboratory evidence, etc and any relevant hospital reports that are available.
   請提供所有手術報告、X光檢查、電腦掃描、及其他影像報告、化驗報告等，或任何有關的醫院報告。

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5. 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。

6. 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.
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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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