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－OSTEOGENESIS IMPERFECTA – TYPE III
危疾－成骨不全症第三型

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. Has Osteogenesis Imperfecta – Type III been definitely diagnosed?
成骨不全症第三型之診斷有否被確認？ ☐ Yes 有 ☐ No 沒有

   On which date was the diagnosis made? 有關疾病之診斷是於何時首次確認？

   ☐☐ MM月 ☐☐ DD日 ☐☐☐☐ YYYY年

   Was the diagnosis confirmed by a pediatrician?
該疾病是否由兒科專科醫生確定？ ☐ Yes 是 ☐ No 否

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

   _____

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。

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。

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

7. Please describe the extent of the disease. 請描述該病的狀況。

i. Is there evidence of multiple fractures of bones? 有沒有多處骨折？ ☐ Yes 有 ☐ No 沒有

ii. Is there evidence of progressive kyphoscoliosis? 有沒有進行性脊柱後側凸畸形？ ☐ Yes 有 ☐ No 沒有

iii. Is there evidence of growth retardation resulted from the disease? 有沒有因此病引致發育遲緩？ ☐ Yes 有 ☐ No 沒有

iv. Is there evidence of hearing impairment resulted from the disease? 有沒有因此病引致聽力損傷？ ☐ Yes 有 ☐ No 沒有

v. If any of the above answers is "Yes", please list below the diagnostic tests, including dates & results (please provide copies of reports).
如上述任何一項答案是"有"，請列出確實有關診斷的檢驗詳情，包括日期及結果。(請提供報告副本以供參考。)

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

Note: please enclose copies of all reports, including neurological reports, blood tests, skin biopsy, x-rays, audiometric and sound-threshold test, CT Scans, MRI, other imaging studies, laboratory evidence, surgical report etc. and any relevant hospital reports that are available.
註：請提供所有報告包括神經系統報告、血液化驗、皮膚切片檢查、X-光檢查、聽力及聲域測驗、電腦掃描、磁力共震、其他影像、化驗及手術報告等，及任何有關的醫院報告。

8 i) Was skin biopsy done to confirm the diagnosis of Osteogenesis Imperfecta – Type III?
有沒有就成骨不全症第三型之診斷進行皮膚切片檢查？ ☐ Yes 有 ☐ No 沒有

ii) If "Yes", the result is: 如"有"，檢驗結果是：☐ Positive陽性 ☐ Negative 陰性
(Please supplement with copy of the relevant report. 請提供相關的報告以供參考。)

9. i) What was the cause of the disease? 該疾病是因何引致？

_____

_____

ii) Was it congenital in nature? 該疾病是否由先天性殘缺或疾病而導致？ ☐ Yes 是 ☐ No 否

10. Present condition of the Insured 受保人現時之病況。

11. 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。

12. 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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