AIA International Limited
(Incorporated in Bermuda
with limited liability)

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 No. 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 – INTELLECTUAL IMPAIRMENT DUE TO SICKNESS OR INJURY 危疾－因疾病或受傷導致智力缺陷

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/DD/YYYY 月/日/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/DD/YYYY 月/日/年

   What were the symptoms? 受保人之病徵。

   _____

   How long had the symptoms been presented? 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 Intellectual Impairment been definitely diagnosed? 智力缺陷之診斷有否被確認?

   ☐ Yes 有 ☐ No 沒有

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

   (/ /) MM/DD/YYYY 月/日/年

   Was the diagnosis confirmed by a registered pediatric psychiatrist? 該疾病是否由兒童精神專科醫生確定?

   ☐ Yes 是 ☐ No 否

   Please give the Name and Address of the pediatric psychiatrist if it is not the undersigned. 若非由填寫此表格之醫生確認，請提供兒童精神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"或"會"，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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7. Please provide full and exact details of the diagnosis. 請提供受保人之所有及確定的診斷詳情。

8. Please describe the extent of intellectual impairment. 請描述智力缺陷之狀況。

i. Date of onset. 病發日期：(/ /) MM/DD/YYYY 月/日/年

ii. Which of the following intellectual impairment(s) has/have the insured suffered? 受保人患有以下哪些智力缺陷?

a. Sub-average general intellectual functioning 整體智力功能低於常人	☐Yes 是	☐No 否
b. Mental handicap 精神殘障	☐Yes 是	☐No 否
c. Learning Disorder 學習障礙	☐Yes 是	☐No 否

If any of the above is yes, please provide details. 如上述任何一項為是，請提供詳情。

_____

_____

_____

iii. What was the cause of the above intellectual impairment(s)? 導致智力缺陷之原因是什麼?

_____

_____

iv. Was/were the above intellectual impairment(s) certified to be resulted solely from the diagnosed sickness or injury by the insured's treating pediatric psychiatrist? 上述智力缺陷是否由受保人的兒童精神專科醫生證實其情況直接由上述確診的疾病或意外導致?

☐ Yes 是 ☐ No 否

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

_____

v. How old was the insured when the diagnosis was made? 受保人被診斷患上智力缺陷時的年齡是? _____

vi. Has the intellectual impairment continuously existed for at least 6 months after the diagnosis was made? 智力缺陷是否在診斷後持續出現至少 6 個月?

☐ Yes 是 ☐ No 否

If yes, how long has the condition been medically documented? 如是，上述病症約存在了多久?

_____

vii. Is the insured's IQ scored below 70? 受保人的智商是否低於 70? ☐ Yes 是 ☐ No 否

If yes, through which IQ test was it confirmed and please state the date of test done and its result? 如是，透過哪種標準智商測試證實及請列出測試日期及其結果?

☐ Raven's Progressive Matrices 瑞文氏標準推理測驗; Date of Test Done 測試日期 : (/ /) MM/DD/YYYY 月/日/年

Result 結果: _____

☐ Wechsler Intelligence Scale for Children 韋氏兒童智力量表; Date of Test Done 測試日期 : (/ /) MM/DD/YYYY 月/日/年

Result 結果: _____

☐ Others, please specify 其他，請列明: _____;Date of Test Done 測試日期 : (/ /) MM/DD/YYYY 月/日/年

Result 結果:_____

(Please provide a copy of the IQ test report for reference. 請提供智商測試報告作參考。)

9. Was/were the above intellectual impairment(s) caused by any of the followings? 上述智力缺陷是否由下列任何一項導致?

☐ Congenital Illness 先天性疾病; Please specify 請列明: _____

☐ Substance Abuse 物質濫用; Please specify 請列明: _____

☐ Others, please specify 其他，請列明: _____

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10. Treatment Details 治療詳情

i. Was the insured required to be admitted into hospital due to the sickness or injury? 受保人是否因為該疾病或意外而需要接受住院治療?
☐Yes 是 ☐No 否

If yes, please state the period(s) of hospital confinement(s). 如是，請列出住院時段。

From 由 (/ /) MM/DD/YYYY 月/日/年 To 至 (/ /) MM/DD/YYYY 月/日/年

Name of Hospital 醫院名稱: _____

Attending Unit 住院科目: _____

Name of Attending doctor 主診醫生名稱 : _____

11. Please enclose copies of all reports, including x-rays, CT scans, other imaging studies, laboratory evidence, IQ Test report, etc. and any relevant hospital reports that are available. 請提供所有報告包括 X-光檢查，電腦掃描，其他影像學報告，智商測試報告等，或任何有關的醫院報告。

12. 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。

13. 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

PLEASE READ THE AIA PERSONAL INFORMATION COLLECTION STATEMENT ("AIA PIC") BEFORE YOU SIGN THIS CERTIFICATE. IF THE AIA PIC STATEMENT IS NOT ATTACHED, YOU CAN ASK FOR A COPY FROM US. Also, the updated version of AIA PIC is available for download from its website: www.aia.com.hk.

All the personal data and other information contained in this Confidential Medical Certificate will be used by us for the processing of the Insured's claim(s), and will also be utilized in accordance with AIA PIC. By asking you to fill in this Certificate, the Insured/Owner has given you the express consent to release his/her personal data and other information to our Company.

個人資料收集及使用

簽署此醫生報告前，**請先閱讀 AIA 個人資料收集聲明。** 如 AIA 個人資料收集聲明未有隨附於本醫生報告，閣下可向我們索取複印本一份。 AIA 個人資料收集聲明的最新版本亦可於以下網址下載：www.aia.com.hk。

所有個人及其他於此醫生報告收集所得的任何資料將會被我們用作處理受保人之索償申請，我們亦可根據 AIA 個人資料收集聲明使用該些資料。 向閣下提出要求填寫此醫生報告即表示受保人/保單持有人已授權閣下可於此報告透露他/她的個人資料及其他資料給我們。

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