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 – RHEUMATIC FEVER WITH VALVULAR IMPAIRMENT (SEVERE CHILD DISEASE)
危疾 - 風濕性心瓣疾病(嚴重兒童疾病)

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"是",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疾病之機會?

☐ Yes 是 ☐ No 否

6. Is the Insured a smoker? ☐ Yes 是 ☐ No 否
受保人是否吸煙人仕?

If "Yes", what is his / her smoking habit?
若為吸煙人仕,他 / 她的吸煙習慣如何?
Daily smoking amount 每日吸煙數量 : _____ for how many years? 吸食年數 : _____

7. 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。

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

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

9. Please describe the extent of the disease.
請描述該疾病之狀況。

i. Was the disease diagnosed according to the Revised Jones Diagnostic Criteria? ☐ Yes 是 ☐ No 否
該病是否由已修訂的 Jones 診斷標準證實?

ii. Was it the first or recurrent attack? ☐ First 首次病發 ☐ Recurrent 復發
屬於首次病發或復發?

iii. Which population group does the patient belong to?
病人屬於何風險群組?
☐ Low 低風險 ☐ Moderate 中風險 ☐ high 高風險

iv. Did the patient exhibit the following signs / symptoms? If yes, please tick the appropriate boxes and provide detail description for signs or symptoms that have been present.
病人是否出現下列徵狀或病徵? 如是，請在適當方格內填上✓號及提供相關徵狀或病徵的詳細描述。

☐ Evidence of preceding group A streptococcal infection
A 組鏈球菌感染

☐ Carditis
心臟發炎
☐ Clinical 臨床 ☐ Subclinical 亞臨床

☐ Arthritis
關節炎
☐ Monoarthritis 單關節炎 ☐ Polyarthritis 多關節炎

☐ Chorea
舞蹈病

☐ Erythema Marginatum
環形紅斑

☐ Subcutaneous Nodules
皮下結節

☐ Arthralgia
關節痛
☐ Monoarthralgia 單關節痛 ☐ Polyarthralgia 多關節痛

☐ Fever 發燒 (≥38.5°C)

☐ ESR ≥60 mm/h ESR
等於或高於每小時60毫米

☐ CRP ≥3mg/dL CRP
等於或高於每分升3毫克

☐ Prolonged PR interval on ECG (for patient's age)
心電圖的PR間期延長 (根據病人年齡)

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

v. Was the diagnosis confirmed by a pediatrician? ☐ Yes 是 ☐ No 否
是否經兒童專科醫生確診?

Please give name and address of the pediatrician confirming the diagnosis if it is not the undersigned.
若非由填寫此表格之醫生確診，請提供確診之兒童專科醫生之姓名及地址。

_____

_____

10.i. Was there an involvement of heart valves? ☐ Yes 是 ☐ No 否
心臟瓣膜是否受影響?

ii. Was there valve incompetence? ☐ Yes 是 ☐ No 否
是否出現心臟瓣膜功能不全?

iii. Was the valve incompetence attributable to rheumatic fever? ☐ Yes 是 ☐ No 否
該心臟瓣膜功能不全是否歸因於風濕熱?

iv. Was the diagnosis confirmed by a cardiologist? ☐ Yes 是 ☐ No 否
是否經心臟專科醫生證實確診?

Please give name and address of the cardiologist confirming the diagnosis if it is not the undersigned.
若非由填寫此表格之醫生確診，請提供確診之心臟專科醫生之姓名及地址。

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_____

v. Was the diagnosis confirmed by quantitative investigations of the valve function? ☐ Yes 是 ☐ No 否
是否根據心瓣功能的數量檢查證實確診?

If yes, please provide the relevant report. 如是，請提供有關報告。

11. Please enclose copies of all reports including all reports, radiological procedures, MRI, CT scanning, electroencephalography, biopsy, laboratory evidence, other imaging studies, etc. and any relevant hospital reports that are available.
請提供所有報告，如放射性治療、磁力共震、電腦掃描、腦電圖、活體檢驗記錄、化驗報告及其他影像報告等，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。

_____

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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。

Policy Number 保單號碼

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