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 No. 身分證號碼

CRITICAL ILLNESS – MOTOR NEURONE DISEASE 危疾－運動神經原疾病

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/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 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/DD/YYYY 月/日/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/DD/YYYY 月/日/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/她的吸煙習慣如何?
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。
.....
.....
.....

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

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 disease. 請描述該病之狀況。

i. Date of oneset
病發日期

M	M	D	D	Y	Y

（月月/日日/年年）

ii. Which of the following forms of motor neurone disease was diagnosed? 下列哪種運動神經原疾病被確診?

☐ Spinal Muscular Atrophy 脊髓性肌肉萎縮症

☐ Progressive Bulbar Palsy 漸進延髓麻痺

☐ Amyotrophic Lateral Sclerosis 肌萎縮性側索硬化症

☐ Primary Lateral Scelrosis 原發性側索硬化症

☐ Others, please specify the exact diagnosis: 其他, 請註明診斷結果: .....

iii. Was there any neurological deficit resulted? 有沒有導致神經虧損? ☐ Yes 有 ☐ No 沒有

If yes, was neurological deficit resulted from the following condition? 如"有", 神經虧損是否由下列情況導致?

a. Progressive degeneration of Corticospinal Tracts? 皮質脊髓束逐漸退化? ☐ Yes 是 ☐ No 否

b. Progressive degeneration of Anterior Horn Cells? 前角細胞逐漸退化? ☐ Yes 是 ☐ No 否

c. Progressive degeneration of Bulbar Efferent Neurons? 延髓傳出神經元逐漸退化? ☐ Yes 是 ☐ No 否

iv. Please give details of the neurological deficit and indicate whether the neurological deficit is expected to be permanent. 請詳細描述神經虧損之情況。該神經虧損之情況是否屬於永久性的？

.....

.....

v. Was the diagnosis confirmed by a neurologist? 是否經腦神經專科醫生確診? ☐Yes 是 ☐No 否

Please give Name and Address of the neurologist confirming the diagnosis if it is not the undersigned. 若非由填寫此表格之醫生確診，請提供確診之專科醫生之姓名及地址。

.....

3. Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedures, etc. and any relevant hospital reports that are available.
請提供所有報告包括放射性治療程序、電腦掃描、化驗報告及其他影像等，或任何有關的醫院報告。

4. 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。

5. 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