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

CARCINOMA-IN-SITU
原位癌

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

   If "no", do you know who is her usual medical physician? 如"否"，請問受保人慣常求診之醫生是誰？

   .....

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 and by whom? 有關疾病之診斷是由誰及於何時首次確認?

   On (/ /) MM/DD/YYYY by Dr. _____

   於 _____ 年_____ 月 _____日由 _____ 醫生首次確認

   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. Other physicians or medical facilities the insured has consulted for this condition. 受保人曾經因此病而就診之其他醫生姓名或醫院名稱及地址。

Name of physician/facility 醫生姓名或醫院名稱	Address 地址	Date of consultation/confinement period (MM/DD/YYYY) 求診日期 / 住院時段（月/日/年）
.....	.....	.....
.....	.....	.....
.....	.....	.....

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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7. Location of the carcinoma-in-situ 原位癌的位置

_____

Dates & results of all the diagnostic tests (e.g. biopsy, cone biopsy, colposcopy with cervical biopsy, Pap smear tests, CT scan, etc.) (Please provide copy of histopathology/cytology/stopathology reports.)
接受檢驗的日期及其結果(如活體檢驗、宮頸錐形活檢、附宮頸活檢的陰道鏡檢查報告、帕氏抹片、電腦掃描等)(請提供病理報告/細胞分析報告/組織學報告副本以供參考。)

(/ /) MM/DD/YYYY 月/日/年

Results. 檢驗結果: _____

If biopsy was not done, please state the reason. 如沒有進行活體檢驗, 請列出原因。

_____

Was abnormal cells or growth previously detected at the location? If so, please state when and the details. 該位置是否曾經探測到有異常細胞或組織生長? 如有, 請列出何時及其詳情。

_____

_____

When did the Insured previously undergo investigations or receive treatment for any abnormality of the claimed illness? Please provide name and address of the attended doctor. 受保人前次因上述原位癌接受檢驗或治療是於何時? 請提供該醫生的姓名及地址。

_____

_____

8. How long has the condition been medically documented? 上述原位癌約存在了多久?

_____

Was there any symptom? If so, please specify the details and how long it has been experienced. 有沒有任何徵狀? 如有, 請列出詳情及該徵狀存在了多久?

_____

_____

9. Was there any penetration of the basement membrane or invasion of the surrounding tissues or stroma by the cancer cells? 癌細胞有否穿透基膜或侵入環繞的組織或氣孔?

☐ Yes 有 ☐ No 沒有

10. What is the staging of the claimed Carcionoma-in-situ according to the TNM / FIGO Staging method? 原位癌疾病的腫瘤級別按 TNM 或 FIGO 分期法為哪一階段?

11. Details with dates of medical treatment performed as well as current medication. 請提供所有治療日期及詳情, 並列出近期服用的藥物名稱。

Was there any surgery performed? 有沒有接受手術治療?

☐Yes 有 ☐No 沒有

If "Yes", please state details of surgical procedure(s) 如 "有" ,請列出接受之手術詳情。

_____

_____

12. Present condition of the insured. 受保人現時之病況。

13. Prognosis. 病情進展。

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14. 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。

15. Is the insured HIV (Human Immunodeficiency Virus) positive? If so, please provide details including the date of diagnosis. 受保人之感染人體免疫力缺乏病毒測試是否屬陽性反應? 如“是”，請提供詳情（包括診斷日期。）

16. 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: _____

17. 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