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

FEMALE PRODUCT 女性保險
New Born Baby Congenital Anomaly 新生嬰兒先天性異常 – SPINA BIFIDA 脊柱裂

Spina Bifida shall mean the failure of the spine to close properly during the first month of pregnancy that results in varying degrees of paralysis, loss of sensation in the lower limbs, difficulty of bowel and bladder control, hydrocephalus and learning disabilities. This anomaly can be detected pre-natally either through a maternal serum alpha-fetoprotein (AFP) screening test, a detailed ultrasound examination or amniocentesis.
「脊柱裂」是指胎兒的脊柱未能於懷孕首月內正當地閉合而導致胎兒有不同程度的癱瘓、下肢失去知覺、難以控制膀胱及大腸功能、腦積水及學習障礙。 此異常情況可以於產前透過母親的血清甲胎蛋白測驗 、 詳細超聲波檢查或羊膜穿刺術而確定。

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 medial physician? 如"否"，請問受保人慣常求診之醫生是誰？

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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

3. 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

4. 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
.....	.....	.....
.....	.....	.....

5. How long has the condition been medically documented? 上述病症約存在了多久?

6. When was the diagnosis made? Please state the date. 診斷是何時被確認? 請列出日期。

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. Please give details of all investigations conducted (including dates and results). Please attach the relevant reports, e.g. maternal serum alpha-fetoprotein (AFP) screening test, detailed ultrasound examination or amniocentesis, supporting this diagnosis.
請提供檢驗詳情，包括日期及結果。 請提供有關報告，如母親的血清甲胎蛋白測驗 、 詳細超聲波檢查或羊膜穿刺術以確立診斷結果。

8. Does the foetus exhibit the following symptoms? 胎兒是否有下列徵狀?

i. Varying degrees of paralysis 不同程度的癱瘓	☐ Yes 有	☐ No 沒有
ii. Loss of sensation in the lower limbs 下肢失去知覺	☐ Yes 有	☐ No 沒有
iii. Difficulty of bowel and bladder control 難以控制膀胱及大腸功能	☐ Yes 有	☐ No 沒有
iv. Hydrocephalus 腦積水	☐ Yes 有	☐ No 沒有
v. Learning disabilities 學習障礙	☐ Yes 有	☐ No 沒有

If any of the above answers is “Yes”, please describe in details. 如以上任何一項為 “是”， 請詳細描述。

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

10. Prognosis. 病情進展 ：

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.
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