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 – RHEUMATOID ARTHRITIS
女性保險 – 類風濕性關節炎

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？

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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

What were the symptoms? 受保人之病徵。

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How long had the symptoms been present? 該病徵約存在了多久?

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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。

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4. Has Rheumatoid Arthritis been definitely diagnosed? 類風濕性關節炎之診斷有否被確認?

☐Yes 有 ☐No 沒有

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. Results & dates of following laboratory tests (Please provide copy of test results):
接受下列化驗的日期及其結果（請提供報告副本以供參考。）

Name of Laboratory Test 化驗項目	Results 化驗結果	Dates (MM/DD/YYYY) 日期（月/日/年）
.....	.....	.....
.....	.....	.....
.....	.....	.....

Note: please enclose copies of all reports, including blood test, biopsy reports, cytology reports, x-rays, CT scans, other imaging studies, laboratory evidence, surgical report etc. and any relevant hospital reports that are available.
註：請提供所有報告包括血液化驗，活體檢視記錄，細胞分析報告，X-光檢查，電腦掃描，其他影像，其他化驗報告，手術報告，或任何有關的醫院報告。

8. Which of the folloing diagnositc criteria were present？出現了何種診斷條件？
- ☐ Morning stiffness in and around joints for at least 1 hour 晨起僵硬超過 1 小時
- ☐ Soft tissue joint swelling for 3 or more joints 3 個或以上的關節發炎
- ☐ Soft tissue swelling in a hand joint 掌指、手腕和近端指間等關節出現關節軟組織腫脹
- ☐ Symmetrical swelling of joints 對稱性的關節腫脹
- ☐ Rheumatoid nodule 類風濕結節
- ☐ Positve rheumatoid factor 類風濕因子呈陽性
- ☐ Radiograph changes on wrist/hands; erosions or juxta-articular osteoporosis X 光檢測發現手部關節轉變；侵蝕或周邊骨質疏鬆
- ☐ Others (please specify) 其他（請指出）：

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How long were the above diagnostic criteria present? 上述診斷條件存在多久?

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9. If Insured is not bedridden, which of the following daily activities the Insured is **NOT** able to perform as a direct result of the Rheumatoid Arthritis (please check the appropriate item) 如受保人不須永久臥床，受保人因類風濕性關節炎**不能**完成下列哪些日常生活活動？(請選擇適當的項目)

- ☐ Getting in and out of a chair or bed without requiring any physical assistance. 在無需任何幫助的情況下，可自行上落床、坐椅及自椅子起立。
- ☐ Ability to move from room to room without requiring any physical assistance. 在無需任何幫助的情況下，可自行由某一間房間移動至另一間房間。
- ☐ The ability to voluntarily control bladder and bowel functions so as to maintain personal hygiene. 有控制膀胱及大腸功能的自發能力，以保持個人衛生。
- ☐ Putting on and taking off all necessary items of clothing without requiring the assistance of another person. 在無需其他人士幫助的情況下，可自行穿著及除掉一切所需衣物。
- ☐ The ability to wash oneself in the bath or shower (including getting in or out of the bath or shower) or wash oneself by any other means 可自行在浴缸或淋浴間進行沐浴或淋浴（包括進出浴缸或淋浴間）或使用其他方式洗澡的能力
- ☐ All tasks of getting food into the body once it has been prepared. 進食已預備好之食物的一切程序。

How long have such inability been medically documented? 根據醫學證據，上列的活動能力已喪失了多久？

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Is such inability expected to be permanent? 已喪失的活動能力是否屬於永久性的？ ☐ Yes 是 ☐ No 否

10. Details of treatment rendered. 治療詳情：

Was there any surgery performed? 受保人有沒有接受手術治療? ☐ Yes 有 ☐ No 沒有

If “Yes”, please provide details of surgical procedure(s). 如 “有” ，請提供手術手術詳情。

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

12. Prognosis. 病情進展

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13. 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。

14. 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呈陽性反應? 如是，請提供詳情包括診斷日期。

15. Please provide details of the Insured's habits in relation to smoking cigarettes (including no. of sticks smoked per day). 請提供受保人的吸煙習慣之詳情包括每日之吸煙數量。

16. 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