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 – ANGIOPLASTY OR ENDARTERECTOMY FOR CAROTID ARTERIES / ENDOVASCULAR TREATMENT OF PERIPHERAL ARTERIAL DISEASE
危疾 – 於頸動脈進行血管成形術或內膜切除術 / 周圍動脈疾病的血管介入治療

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. 請提供受保人之所有確定的診斷詳情。

2. Please describe the extent of the disease. 請描述該病之狀況。

i. Which arteries are involved and what is the degree of narrowing (%) in respect of each involved artery? 請列出所有收窄了的動脈名稱及其血管腔收窄之程度（百分比）。

.....

Through what angiographic imaging was the above narrowing confirmed? 上述的動脈收窄經由甚麼心血管影像檢查確認？

.....

Was the diagnosis confirmed by a specialist in vascular diseases? 是否由血管疾病專科註冊醫生確診? ☐ Yes 是 ☐ No 否

Please give the Name and Address of the specialist if it is not the undersigned. 若非由填寫此表格之醫生進行，請提供血管疾病專科註冊醫生之姓名及地址。

……..

ii. Details of procedure done 手術詳情。

Was endarterectomy, angioplasty and/or stenting, atherectomy or any other intra-arterial procedures done? 有否接受動脈內膜切除術、血管成形術及/或進行置入支架、動脈粥樣瘤清除手術、或任何其他經動脈進行的手術？

☐ Yes 有 ☐ No 沒有

If the involved arteries are the ones supplying blood to lower limbs or upper limbs, was/were amputation of the limb(s) done? 如收窄了的動脈乃為下肢或上肢供血的動脈，有否進行截肢手術?

☐ Yes 有 ☐ No 沒有

If any of the above 2 questions is "yes", please state which procedure was done and to which artery: 如上述兩項其中一項為 "有" ， 請列出受保人所接受的手術程序名稱及所針對之動脈名稱。

.....

.....

Date and place of surgery 手術日期及地點:

Date of surgery 手術日期 : (/ /) MM/DD/YYYY 月/日/年

The hospital where the surgery was performed 手術醫院 : ……..

Name of Surgeon 手術醫生 : ……..

Was the surgery considered medically necessary by the specialist in vascular diseases? 手術是否由血管疾病專科註冊醫生確認為醫療所需?

☐ Yes 是 ☐ No 否

3. Please enclose copies of all surgical reports, x-rays, CT scans, and other imaging studies, laboratory evidence, angiograms, etc. and any relevant hospital reports that are available.
請提供所有手術報告、X 光檢查、電腦掃描、及其他影像報告、化驗報告及血管造影術報告等，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。

Policy Number 保單號碼

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。

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