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 – CANCER / EARLY STAGE MALIGNANCY
危疾 – 癌 / 早期惡性腫瘤

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/她的吸煙習慣為何?

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 and the site involved and the precise histology of the tumour. 請提供受保人之所有及確定的診斷詳情，包括該腫瘤之確定的位置及細胞組織分析。

2. Is the diagnosis confirmed with histological examination? 診斷是否經病理分析確定？ ☐ Yes 是 ☐ No 不是

If yes, the type and date of histological examination performed. 若是，所作病理分析之類別及進行日期。

.....

(/ /) MM/DD/YYYY 月/日/年

If histological examination is not done, what is the reason? 若未有進行病理分析，原因為何？

.....

Histological result :

(a) Is the histological result carcinoma-in-situ? 病理分析結果是否原位癌？ ☐ Yes 是 ☐ No 不是

(b) Is there uncontrolled growth of malignant cells? 癌細胞有否不受控制地生長? ☐ Yes 有 ☐ No 沒有

(c) Is there any clear stromal invasion of malignant cells? 癌細胞有否明顯入侵基質? ☐ Yes 有 ☐ No 沒有

(d) What is the staging of the cancer according to the TNM classification system? (For Chronic Lymphocytic Leukemia, please state the RAI Stage.) 根據 TNM 評級系統, 此癌症屬於哪一階段？（慢性淋巴性白血病, 則請列出其 RAI 級別。）

.....

(e) Is there any distant metastasis? If yes, any identified secondary site? ☐ Yes 有 ☐ No 沒有
癌細胞有否擴散至其他器官？如有，已確認被擴散的器官？

.....

Please enclose copies of all reports including biopsy records, cytology reports, X-rays, CT scans, other imaging studies, laboratory evidence, surgical report, etc, and any relevant hospital reports that are available. 請提供所有診斷報告，如活體檢視記錄，細胞分析報告，X 光檢查，電腦掃描，超聲波，驗血，心電圖，及其他化驗報告等，或任何有關的醫院報告。

3. What is the nature of treatment? 受保人接受哪一種治療？

☐ Surgical 外科手術 ☐ Radiotherapy 放射性治療

☐ Chemotherapy 化學治療 ☐ Palliative 姑息治療

☐ Others, please specify: 其他, 請註明: _____

Please provide details of procedure(s): 請提供治療之詳情:

.....

4. Whether HIV Infection is present in the Insured 受保人有否感染人體免疫力缺乏病毒 (HIV)？ ☐ Yes 有 ☐ No 沒有

If yes, please give details. 如有，請提供詳情。

.....

5. 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。

6. 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