

Critical Illness – Cancer 危疾 – 癌症

PART II - To be completed by doctor at Insured's/Claimant's expense (Chinese version is for reference only - English version shall prevail)

第二部份 – 由主診醫生填寫，所需費用由索償人承擔（中文版本只供參考，一切以英文版本為準）

Policy No. 保單號碼				
Name of Insured 受保人姓名	ID Card No. 身份證號碼	Age 年齡	Date of Birth 出生日期	Sex 性別

GENERAL INFORMATION 一般資料

<p>1. Are you the Insured's usual medical physician? 閣下是否受保人慣常求診之醫生？</p> <p><input type="checkbox"/> Yes, period of medical records extends from 是，醫療紀錄可追溯至 _____ (DD 日 / MM 月 / YY 年)</p> <p><input type="checkbox"/> No 否</p>			
<p>2. When were you first consulted for this illness? 受保人何時首次就此病症向您求診？ _____ (DD 日 / MM 月 / YY 年)</p>			
<p>3. What were the symptoms? 受保人求診時有何徵狀？</p>			
<p>4. How long had the symptoms been present at that time? 徵狀當時已持續了多久？</p>			
<p>5. Are you aware of whether the Insured had previously suffered from this illness or any related conditions? 受保人以往是否患有相同或類似病況？</p> <p><input type="checkbox"/> Yes 是</p> <p><input type="checkbox"/> No 否</p> <p>If "yes", please provide names, addresses and dates of doctors or facilities which the Insured has been referred and/or admitted to and the resulting diagnosis. 如「是」，請提供受保人就此病症求診之醫生或醫療機構名稱、地址及求診日期，及診斷結果。</p>			
Name of physician / facility 醫生 / 醫療機構名稱	Address 地址	Date of consultation / confinement period 求診 / 入住日期	Diagnosis 診斷
<p>6. On which date was the diagnosis made? 病症確診日期 _____ (DD 日 / MM 月 / YY 年)</p>			
<p>7. On which date was the Insured first made aware of it? 受保人知悉有關病症之日期 _____ (DD 日 / MM 月 / YY 年)</p>			
<p>8. Is there anything in the Insured's family history which would have increased the risk of this illness? 受保人是否有親屬曾患相同或類似病症，或會增加受保人患病的機會？</p> <p><input type="checkbox"/> Yes, please provide details 是，請提供詳情 _____</p> <p><input type="checkbox"/> No 否</p>			
<p>9. Please provide names, addresses and dates of doctors and facilities which the Insured has been referred and/or admitted to for diagnosis/treatment of this current episode / illness. 請提供受保人就此病症獲得診斷 / 治療之醫生和醫療機構名稱、地址及日期。</p>			
Name of physician / facility 醫生 / 醫療機構名稱	Address 地址	Date of consultation / confinement period 求診 / 入住日期	

DETAILS OF THE INSURED'S ILLNESS 受保人之病症詳情

1. Please provide full and exact details of the diagnosis, the site involved and the precise histology of the tumour. If the diagnosis is leukaemia, please give details of the actual type. 請提供與診斷相關之完整及確實的詳情、腫瘤的擴散程度及病理。如診斷為白血病，請提供種類。
2. Please describe the extend of the disease. 請描述病症的嚴重程度及範圍。 i. Stage of the tumor 腫瘤的分期 _____ ii. Was the cancer completely localized? 是否原位生長而沒有轉移？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 iii. Was there regional or distant spread? 是否轉移至原位器官或遠距離轉移？ <input type="checkbox"/> Yes, please describe degree of regional nodal involvement and / or extent of distant spread 是。請描述局限性侵略其他細胞組及 / 或遠距離轉移之程度。 _____ <input type="checkbox"/> No 否
3. Nature of treatment 治療類型 <input type="checkbox"/> Surgical 手術 <input type="checkbox"/> Radiotherapy 放射治療 <input type="checkbox"/> Chemotherapy 化療 <input type="checkbox"/> Palliative 紓緩治療 Please provide details of treatment(s): 請提供詳細治療程序: _____
4. Investigations 檢查 i. Was a biopsy of the tumour performed? 腫瘤是否已進行活體切片檢查？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 ii. 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，包括活體檢視記錄、細胞分析報告、X光檢查、電腦斷層掃描、其他影像檢查、化驗報告、手術報告等，及其他相關的醫療報告。
5. Please state if the Insured has suffered / been treated for any other illness(es) / complaints other than this Critical Illness. 如受保人曾確診此危疾以外的其他病症或獲得治療，請在此說明。
6. Please provide 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的資料。

I hereby certify that I have personally examined and treated the above-named Insured for the above disability and that the facts as given above represent my opinion of his/her condition. 本人在此聲明，本人親自檢查及治療上述受保人之病症，以上陳述乃本人對受保人健康狀況之意見。

Name of doctor and qualification

醫生名稱及醫學資格

Signature and official chop

簽署及蓋印

Address and telephone number

地址及電話

Date

日期