CRISIS COVER CLAIM FORM 危疾理賠申請書

Policy No. 保單號碼 _____

Part II - Medical Certificate (to be completed by the Attending Physician, duly qualified and registered, at claimant's own expense) in relation to :

第二部份 - 醫療報告 (由索償人自費聘請主診註冊西醫填寫) 有關於 :

Total and Permanent Disability
The Life Assured has become totally and permanently disabled as a result of sickness or injury before age 65. The Life Assured is considered to be totally and permanently disabled if (i) he or she is totally and permanently incapable of being engaged in any occupation, business or activity which pays an income or profit. The above disability must have lasted without interruption for at least 180 consecutive days; or (ii) he or she suffers the following conditions: Total and irrecoverable loss of sight in both eyes; or Total and irrecoverable loss of use of two limbs (at or above thewrist or ankle joints); or Total and irrecoverable loss of sight of one eye and total and irrecoverable loss of use of one limb (at or above the wrist or anklejoint).
"Loss of use" means complete and permanent paralysis or actual severance. If the Life Assured is below age 15 or is unemployed at the time of becoming totally and permanently disabled, he or she is only considered to be totally and permanently disabled if he or she satisfies the conditions as specified in (ii) above. Such disabilities must be certified by a Registered Doctor acceptable to us.

完全及永久傷殘
受保人於65歲前因受傷或患病導致完全及永久傷殘。在下列情況下，受保人將被視爲完全及永久傷殘：(i) 完全及永久地沒有能力從事任何可獲得收入或利潤的職業、業務或活動。上述傷殘必須不間斷持續超過180日；或(ii) 受保人：雙眼完全失去視力並無法復原；或完全及不可復原地喪失使用兩肢(在手腕或足踝關節或以上)的能力；或 一隻眼睛完全失去視力並無法復原，及完全及不可復原地喪失使用任何一肢（在手腕或足踝關節或以上）的能力。
「喪失使用能力」是指完全及永久性癱瘓或切斷。假如受保人於開始完全及永久傷殘時的年齡不足15歲或並非從事任何職業，他/她必須符合上述第(ii)點的情況下才會被視爲完全及永久傷殘。有關傷殘情況須由本公司認可接納的註冊醫生以書面證明。

Name of Patient 病人姓名	ID / Passport No. 身份證 / 護照號碼	Age & Sex 年齡及性別

1. Are you the patient's usual physician? 你是否病人慣常求診的醫生?

☐ Yes, medical records date back to 是，醫療紀錄可溯至 |_____|_____|_____| (DD/MM/YY) 日/月/年 ☐ No 不是

2. When were you first consulted for this or related illness? 病人首次因相同或相關病症向閣下求診的日期?

|_____|_____|_____| (DD/MM/YY) 日/月/年 Symptoms presented were: 病徵包括 : _____

3. According to the patient, how long had he / she been experiencing these symptoms before the first consultation?
根據病人所提供的資料，病人在首次求診前，其病徵已存在多久?

Since |_____|_____|_____| (DD/MM/YY) OR for _____day(s)_____ month(s) _____year(s)
從 日/月/年 或 已存在 日 月 年

4. (a) Clinical diagnosis 臨床診斷

(b) When was it made? 何時確實這診斷? |_____|_____|_____| (DD/MM/YY) 日/月/年

(c) When was the patient informed of the clinical diagnosis? 病人何時被醫生告知其所患的臨床病症及診斷?

|_____|_____|_____| (DD/MM/YY) By (name & address of physician): _____
日/月/年 由 (醫生姓名及地址)

(d) How long, in your opinion, has the patient suffered from this illness before his / her first consultation? _____
根據閣下的意見，病人在接受第一次診療之前，該病症已持續了多久?

5. (a) **Final diagnosis 最後診斷**

(b) Date of final diagnosis: 最後診斷日期 |_____|_____|_____| (DD/MM/YY) 日/月/年

(c) When was the patient informed of the diagnosis? 病人何時被醫生告知其所患的病症及診斷?

|_____|_____|_____| (DD/MM/YY) By (name & address of physician): _____
日/月/年 由 (醫生姓名及地址) :

6. Please provide full details of the diagnosis and its clinical basis. 請提供所有診斷及臨床診斷的詳情

7. Was the patient **referred to** you from other physician(s)? 病人是否由其他醫生**轉介**?

☐ Yes, |_____|_____|_____| (DD/MM/YY) By (name & address of physician): _____ ☐ No 不是
是， 日/月/年 由 (醫生姓名及地址) :

8. Has the patient ever been treated for the **same/related conditions** ? 病人有否曾經接受**相同/相關**的病症治療？

☐ Yes, please provide details : 有，請詳述 : ☐ No 沒有

Consultation Dates (DD/MM/YY) 就診日期 日/月/年	Physician / Hospital 醫生/ 醫院全名	Diagnosis 診斷	Treatment and Investigation Results / Hospitalization 任何醫療診治及檢查結果 / 住院詳情

9. Is there any patient's family history which would increase the risk of this illness? 病人是否因其任何的家族病史而增加患上此疾病的機會?

☐ Yes, please provide details : 有，請詳述 : _____ ☐ No 沒有

10. Does the patient smoke cigarette? 病人是否有吸煙習慣?

☐ Yes, has been smoking since 有，由|_____|_____|_____| (DD/MM/YY)日/月/年開始吸煙 ☐ No 沒有

☐ Ex-smoker, started on|_____|_____|_____| (DD/MM/YY),ceased on |_____|_____|_____| (DD/MM/YY)
前吸煙者 ， 開始於 (日/月/年) ， 於 (日/月/年) 停止

11. All consultants, specialists and hospitals to which your patient has been referred to or attended for this illness
病人因此病症而曾接受過診治的，或曾被轉介過的所有醫生 (普通科及專科) 和醫院的名稱

Consultation Date (DD/MM/YY) 就診日期 日/月/年	Physician / Hospital 醫生/ 醫院全名	Diagnosis 診斷	Treatment and Investigation Results / Hospitalization 任何醫療診治及檢查結果 / 住院詳情

12. (a) Was the patient totally and permanently unable to engage in ANY occupation, business or activity which pays an income or profit due to sickness or injury ?
病人是否完全及永久地沒有能力從事**任何**可獲得收入或利潤的職業、業務或活動?

☐ Yes, from |_____|_____|_____| (DD/MM/YY) , please provide details: ☐ No 不是
是，自 (日/月/年) 開始, 請詳述:

(b) Did the above disability last without interruption for at least 180 consecutive days?
上述傷殘是否不間斷地持續超過180日?

☐ Yes 是
☐ No , from |_____|_____|_____| (DD/MM/YY) to |_____|_____|_____| (DD/MM/YY) or approximate _____ days/ weeks / months
沒有，自 (日/月/年) 到 (日/月/年) 或 大約 天 / 星期 / 月

13. Does the patient suffer from the following conditions? If yes, please provide details:
病人有否以下情況? 如是, 請詳述:

Total and irrecoverable loss of
完全及不可復原地喪失:

(a) Sight in both eyes
雙眼的視力
☐ Yes, details: 有，詳情:
☐ No 沒有

(b) Use of two limbs (at or above thewrist or ankle joints)
使用兩肢(在手腕或足踝關節或以上) 的能力
☐ Yes, details: 有，詳情:
☐ No 沒有

(c) Sight of one eye and use of one limb (at or above the wrist or anklejoint)
一隻眼睛的視力及使用任何一肢（在手腕或足踝關節或以上）的能力
☐ Yes, details: 有，詳情:
☐ No 沒有

15. What is the prognosis of the patient? 病人現時進展及狀況

16. What tests were performed to confirm the diagnosis? (Please enclose copies of all laboratory reports and relevant medical reports that are available)
有什麼檢驗結果讓閣下能確定此診斷? (請提供有關檢驗報告及醫療報告副本)

Test Date (DD/MM/YY) 檢驗日期(日/月/年)	Test Item 檢驗項目	Result / Diagnosis 結果/ 診斷

17. Is the disease diagnosed to be directly or indirectly caused by or result from 診斷病症是否直接或間接由下列引起或導致
☐ self-inflicted injuries while sane or insane 在神志正常或失常的情況下蓄意自殘
☐ Wilful misuse of any alcohol,narcotic or drug 酗酒，濫用葯物或毒品

Please give details if any of the above item(s) is/are applicable. 如上述適用者， 請提供詳情

18. Other additional information for the current diagnosis 其他有關此診斷結果之額外資料

Name of Physician _____ Qualification _____
醫生姓名 資歷
Hospital Name (if applicable) _____ Telephone No. _____
醫院名稱(如適用) 聯絡電話
Address _____
地址
Signature & Hospital/ Physician's Chop _____ Date (DD/MM/YY) _____
醫院/ 醫生簽署及蓋印 日期 (日/月/年)