Generali Life (Hong Kong) Limited 忠意人壽（香港）有限公司

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Hong Kong Branch

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Internal Use Only **只供內部使用**
Claim No. 理賠編號

Critical Illness Claim Form – Part II
危疾賠償申請表 – 第二部份

Policy Number
保單號碼 | | | | | | | | |

Private & Confidential 私人及機密

For claim of "Cancer" / "Carcinoma-in-situ" / "Early Stage Malignancy" / "Benign Brain Tumor"
適用於「癌症」/ 原位癌」/「早期癌症」/「良性腦腫瘤」索償

TO BE COMPLETED BYTHE ATTENDING PHYSICIAN / SURGEON AT THE CLAIMANT'S OWN EXPENSES
由主診醫生填寫，所需費用由索償人自行承擔

Important note 重要事項
Your patient is insured with us and to enable us to assess the claim, please complete this report with as much details as you can possibly provide. Your kind assistance will help expedite the claim settlement.
閣下的病人為本公司的受保人，請閣下詳細填寫此申請表並盡可能提供一切有關資料，以便本公司審核此索償。閣下的協助可使本公司加快索償安排。

Name of the Patient (Insured) 病人（受保人）姓名		HKID Card / Passport No. 香港身份證 / 護照號碼	

Details of the consultation for current illness
就是次疾病求診的詳情

First consultation date for this illness
就此疾病的首次求診日期 _____ / _____ / _____ (dd/mm/yyyy) (日/月/年)

Date symptoms first appeared
病徵首次出現日期 _____ / _____ / _____ (dd/mm/yyyy) (日/月/年)

Chief complaints / symptoms
主訴 / 病徵 _____

Final diagnosis
最終確診 _____

Date of diagnosis
確診日期 _____ / _____ / _____ (dd/mm/yyyy) (日/月/年)

Previously treated for same/related disorder? ☐ Yes (please provide details) 是（請提供詳情） ☐ No 否
是否曾因同類或相關疾病接受治療？

_____

_____

Was the patient hospitalized for treatment due to this illness?
病人是否就此疾病曾入住醫院接受治療？

☐ Yes (please provide details) 是（請提供詳情） ☐ No 否

Period of Hospitalization
住院時期 _____

Name of Hospital
醫院名稱 _____

Any surgery performed during hospitalization? ☐ Yes (please provide details) 是（請提供詳情） ☐ No 否
住院期間是否有進行手術？

Date of surgery
手術日期 _____ / _____ / _____ (dd/mm/yyyy) (日/月/年)

Name of surgery
手術名稱 _____

Other treatment performed
曾進行的其他治療 _____

Brief discharge summary (including investigation tests & results, results of the treatments, any complications and follow-up plans)
出院撮要（包括確診測試及結果、治療結果、有否併發症及跟進計劃）

_____

_____

Had the patient previously referred by other physician?
病人是否經其他醫生轉介？

☐ Yes (please provide name & address of the doctor) 是（請提供醫生姓名及地址） ☐ No 否

Details of the current cancer / tumor
是次癌症 / 腫瘤詳情

Site of the tumor
腫瘤位置 _____

Staging of the tumor
腫瘤級別 _____ Staging System
所用級別系統 _____

Was it Carcinoma-in-situ? ☐ Yes 是 ☐ No 否
是否屬原位癌？

Was the tumor completely localized? ☐ Yes 是 ☐ No 否
腫瘤是否完全在原位生長？

Was there uncontrolled growth of malignant cells? ☐ Yes 是 ☐ No 否
惡性細胞是否不受控制地生長及蔓延？

Was there any invasion of adjacent tissue or regional lymph node? ☐ Yes 是 ☐ No 否
腫瘤是否已浸潤至其他鄰近細胞或淋？

Was there distant metastasis to other organ(s)? ☐ Yes 是 ☐ No 否
腫瘤是否已擴散至其他身體器官？

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

If yes, please provide details (including type of examination & result) and enclose the histological report.
若是，請提供詳情（包括病理分析類別及結果）及附上病理分析報告。

_____

If no, please provide the reason(s) of not performing the histological examination in details.
若否，請詳述未有進行病理分析的原因。

_____

If the diagnosis is Leukaemia, please provide details here.
如診斷為白血病，請在此提供詳情。

Is it Chronic Lymphocytic Leukemia? ☐ Yes 是 ☐ No 否
是否慢性淋巴細胞白血病？

Please confirm the RAI stage.
請確定該 RAI 分期。 _____

If the diagnosis is skin cancer, please provide details here.
如診斷為白血病，請在此提供詳情。

Is it malignant melanoma? ☐ Yes 是 ☐ No 否
是否惡性黑色素瘤？

If yes, please provide the biopsy report and result.
若是，請提供活組織檢查報告及結果。

If the patient suffered from brain tumor, please provide details here.
若病人患有腦瘤，請在此提供詳情。

Site of brain involved
所處腦部位置 _____

Is it tumor of the acoustic nerve, in pituitary gland or spine? ☐ Yes 是 ☐ No 否
是否聽神經瘤，或位於腦垂體或脊髓？

Is the tumor in the form of cysts, granulomas, haematomas and other malformations in or of the arteries or veins of the brain? ☐ Yes 是 ☐ No 否
該腫瘤是否囊腫、肉芽腫、血腫、腦部動脈或靜脈血管畸形？

If yes, please provide details.
若是， 請提供詳情。 _____

Details of all diagnostic tests (apart from above mentioned) performed and the result.
所有診斷檢驗（除上述已提及外）的詳情及結果。

Please enclose copies of the diagnostic test and laboratory reports.
請附上診斷及化驗報告。

Date of Test 檢驗日期	Test Item 檢驗項目	Result 結果
_____	_____	_____
_____	_____	_____
_____	_____	_____

Treatment details.
治療詳情。

Type(s) of treatment administered 治療種類 Details 詳情

☐ Radiotherapy 電療 _____
☐ Chemotherapy 化療 _____
☐ Hormonal therapy 荷爾蒙治療 _____
☐ Target therapy 標靶治療 _____
☐ Surgical 外科手術 _____
☐ Palliative 舒緩治療 _____
☐ Others 其他 _____

Date of treatment
治療日期 _____ / _____ / _____ (dd/mm/yyyy) (日/月/年)

Is there any patient's family history or other precipitating factors which would have increased the risk of this illness? 是次疾病是否因任何家族病史或其他因素促使增加患上此疾病的機會？	☐ Yes (please provide details) 是（請提供詳情） ☐ No 否
Did the patient have any of the following habits - smoking, drinking or drugs taking? 病人是否有以下習慣 - 吸煙、飲酒或服用藥物？	☐ Yes (please provide details) 是（請提供詳情） ☐ No 否 ☐ Smoking 吸煙 ☐ Drinking 飲酒 ☐ Drug taking 服用藥物 Duration 持續時間 _____ Consumption per day 每天用量 _____
Do you know whether the patient was suffering from any other major, chronic or congenital disease? 你是否知道病人曾患有任何其他嚴重、慢性或先天疾病？	☐ Yes (please provide details) 是（請提供詳情） ☐ No 否
Please list details of all medical conditions (apart from what have mentioned above) that the patient had ever consulted you with. 請提供病人過去曾向你求診的所有醫療病況詳情（除上述已提及外）。	Consultation date 求診日期 / Complaints/Symptoms 主訴 / 病徵 / Diagnosis 確診 / Treatment given 所提供治療 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
Was there any usual physician of the patient other than you? 病人是否有其他慣常求診的醫生？	☐ Yes (please provide name & address of the doctor) 是（請提供醫生姓名及地址） ☐ No 否
Any additional information you consider relevant to this claim. 其他與是次索償有關的資料。	

Declaration 聲明

I hereby certify that I have personally examined and treated the patient in connection to the above condition and that the facts as given above present my opinion of his/her condition and all are true to the best of my knowledge and belief. I hereby declare that no information has been withheld by me at the request of the patient or his/her family.

本人謹此聲明曾親自為病人檢查及作出診治，以上填報的各項資料乃本人基於病人的情況而提供意見，所有答案，就本人所知所信，均為事實全部並確實無訛。本人在此聲明，沒有任何病人或其家屬要求本人隱瞞任何資料。

Name of Attending Physician / Specialist and Qualifications
主診 / 專科醫生姓名及資歷

Address and Contact No.
地址及聯絡電話號碼

Signature of Attending Physician / Specialist (with chop)
主診 / 專科醫生署名（蓋印）

Date (dd / mm / yyyy)
日期 (日 / 月 / 年)