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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

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Private & Confidential 私人及機密

For claim of "Stroke"
適用於「中風」索償

TO BE COMPLETED BY THE 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 _____
	Duration of the symptoms 病徵出現時期 _____
	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? <input type="checkbox"/> Yes (please provide details) <input type="checkbox"/> No 是否曾因同類或相關疾病接受治療? 是(請提供詳情) 否
Was the patient hospitalized for treatment due to this illness? 病人是否就此疾病曾入住院院接受治療?	<input type="checkbox"/> Yes (please provide details) 是(請提供詳情) <input type="checkbox"/> No 否
	Period of Hospitalization 住院時期 _____
	Name of Hospital 醫院名稱 _____
	Any surgery performed during hospitalization? <input type="checkbox"/> Yes (please provide details) <input type="checkbox"/> No 住院期間是否有進行手術? 是(請提供詳情) 否
	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) 出院摘要(包括確診測試及結果、治療結果、有否併發症及跟進計劃) _____ _____	

<p>Had the patient previously referred by other physician? 病人是否經其他醫生轉介？</p>	<input type="checkbox"/> Yes (please provide name & address of the doctor) 是 (請提供醫生姓名及地址) <input type="checkbox"/> No 否			
<p>Details of the stroke 有關中風詳情</p>	<p>Has there been an infarction of brain tissue? 是否有腦組織梗塞？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>Has there been any cerebral and subarachnoid haemorrhage? 是否發生大腦及蛛網膜下出血？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>Has there been any cerebral embolism and cerebral thrombosis? 是否出現腦栓塞及腦血栓？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>Is there any evidence of permanent neurological damage? 是否有證據顯示永久性神經功能受損？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>If yes, please provide details including type and duration of the damage. 若是，請提供詳情，包括神經功能受損情況及維持時期。</p> <p>_____</p> <p>_____</p>			
<p>Please provide details and results of all investigation performed, such as MRI, CT scanning or other reliable imaging techniques. 請提供曾進行檢驗的詳情及結果，包括磁力共振、電腦斷層掃描、或其他可靠的影像檢查。</p> <p><i>Please enclose copies of all the test reports. 請附上所有檢驗報告。</i></p>	<p>Date of Test 檢驗日期</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Test Item 檢驗項目</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Result 結果</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p>What is the current condition of the patient? Please provide details. 病人現時狀況如何？請詳述。</p>				
<p>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？</p>	<input type="checkbox"/> Yes (please provide details) 是 (請提供詳情) <input type="checkbox"/> No 否			
<p>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？</p>	<input type="checkbox"/> Yes (please provide details) 是 (請提供詳情) <input type="checkbox"/> No 否 <input type="checkbox"/> Smoking 吸煙 <input type="checkbox"/> Drinking 飲酒 <input type="checkbox"/> Drug taking 服用藥物 Duration 持續時間 _____ Consumption per day 每天用量 _____			
<p>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？</p>	<input type="checkbox"/> Yes (please provide details) 是 (請提供詳情) <input type="checkbox"/> No 否			
<p>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)。</p>	<p>Consultation date 求診日期</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Complaints/Symptoms 主訴 / 病徵</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Diagnosis 確診</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Treatment given 所提供治療</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>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？</p>	<input type="checkbox"/> Yes (please provide name & address of the doctor) 是 (請提供醫生姓名及地址) <input type="checkbox"/> 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)