OneDegree

CONFIDENTIAL MEDICAL CERTIFICATE 醫生報告

CRITICAL ILLNESS – Cancer/Early Stage Malignancy/Carcinoma-in-situ

危疾 – 癌／早期惡性腫瘤／原位癌

PART II - To be completed by doctor at the expenses of the Insured/ Claimant

第二部份（由主診醫生填寫，所需費用由受保人或申請人承擔。）

Policy No. 保單號碼	
Name of Insured 受保人姓名	HKID Card No. 身分證號碼

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？

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？

○ Yes 是 ◉ No 否

Day 日 Month 月 Year 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？

Day 日 Month 月 Year 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 the resulting diagnosis and dates of consultations
如"是"，請提供詳細診斷結果及求診日期。

The resulting diagnosis 詳細診斷結果

Day 日 Month 月 Year 年

4. On which date was the diagnosis made?
有關疾病是何時首次確診 ？

Day 日 Month 月 Year 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？

Day 日 Month 月 Year 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

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

6. Is the Insured a smoker? 受保人是否吸煙人仕？ If "Yes", what is his/her smoking habit? 如"是"，他/她的吸煙習慣為何？	○ Yes 是 ○ No 否 Daily smoking amount 每日吸煙數量: _____ for how many years? 吸食年數: _____
7. Does the Insured have alcohol drinking habit? 受保人是否有飲酒習慣？ If "Yes", what is his/her drinking habit? 如"是"，他/她的飲酒習慣為何？	○ Yes 是 ○ No 否 Daily alcohol consumption 每日飲酒數量: _____ for how many years? 飲酒年數: _____
8. Does the Insured have any drug addiction? 受保人是否藥物成癮？ If "Yes", what is his/her drug addition? 如"是"，他/她的用藥習慣為何？	○ Yes 是 ○ No 否 Name and type of drug 藥物品種及名稱: _____ for how many years? 服食藥物年數: _____

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。

Name(s) 醫生姓名	Name of Hospital (s) 醫院名稱	Address 地址

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診斷結果與詳情，包括該腫瘤之確定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 否
If "yes", please provide type and date of histological examination performed: 如"是"，請提供所作病理分析之類別及進行日期：	The type of histological examination 病理分析之類別 Day 日 Month 月 Year 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 病理分析結果:

(a) Is the histological result carcinoma-in-situ? 病理分析結果是否原位癌？	○ Yes 是 ○ No 否
(i) If "yes", please provide type of carcinoma-in-situ and circle the related grading: 如"是"，請提供原位癌的種類及圈出相關階段：	○ Cervical intraepithelial neoplasia: grade I (CIN I)/ grade II (CIN II)/ grade III (CIN III) 子宮頸表層細胞癌變：第一階段/ 第二階段/第三階段 ○ Prostatic intraepithelial neoplasia: grade I (CIN I)/ grade II (CIN II)/ grade III (CIN III) 前列腺表層細胞癌變：第一階段/ 第二階段/ 第三階段

	○ Skin carcinoma-in-situ 皮膚原位癌 ○ Others. Please provide details: 其他. 請提供詳情： _____
(ii) Is carcinoma-in-situ confirmed by a biopsy? 原位癌疾病有沒有以活組織檢查術確定？	○ Yes 有 ○ No 沒有
If yes, please provide biopsy report. 如 “有” ，請提供活組織檢查報告	
(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? 癌細胞有否擴散至其他器官？	○ Yes 有 ○ No 沒有
If yes, any identified secondary site? 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，如活組織檢查報告，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 Treatment 緩和治療 ☐ 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)？ If yes, please give details: 如有，請提供詳情：	○ Yes 有 ○ No 沒有
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。	

I / We declare that all information given is accurate and true to the best of my/our knowledge and belief.
本人／我們聲明本人／我們於索償申請書中的每一項答案為所知及所信之事實及其全部。

Personal Data Collection and Use 個人資料收集及使用

Please read our Company's Personal Information Collection Statement ('PICS") before you sign this Certificate. The latest version of PICS is made available at https://odhk.blob.core.windows.net/common/Personal-Information-Collection-Statement.pdf

在簽署此醫生報告前，請先閱讀本公司的個人資料收集聲明。本公司最新版本的個人資料收集聲明可於此下載：
https://odhk.blob.core.windows.net/common/Personal-Information-Collection-Statement.pdf 。

All the personal data and information contained in this Confidential Medical Certificate will be used by us for the processing of the Insured's claim(s) and will be utilized in accordance with our PICS. By asking you to fill in this Certificate, the Insured/Policyholder has given you express consent to release his/her personal data and other information to our Company.

所有個人及其他透過此醫生報告收集所得的資料將會被我們用於處理受保人之索償申請，而我們亦可根據個人資料收集聲明使用該些資料。受保人/保單持有人以向閣下要求填寫此醫生報告，表示受保人/保單持有人已授權閣下於此報告透露他/她的個人資料及其他資料予本公司。

Day 日 Month 月 Year 年

Signature and official chop 簽署及蓋印

Date signed 簽署日期

Name of doctor and qualification 醫生姓名及醫學資格

Address 地址

Telephone number 聯絡電話