OneDegree

CONFIDENTIAL MEDICAL CERTIFICATE 醫生報告

CRITICAL ILLNESS – Other Than Cancer/Early Stage Malignancy/Carcinoma-In-Situ, Heart Attack, Stoke

危疾 –癌／早期惡性腫瘤／原位癌、中風、心臟病以外疾病

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. Please provide full and exact details of the diagnosis. 請提供受保人之所有診斷結果與詳情。	
3. 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？ 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 ？	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 ？ 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 Day 日 Month 月 Year 年
5. Was there any diagnostic testing done? 有否接受過任何診斷性測試？ If yes, please provide name, date and findings of each diagnostic test performed, and copies of any studies. 如"有"，請提供每項診斷的日期、結果及所有診斷報告。	○ Yes 是 ○ No 否
6. Type & Date of Surgery Treatment 手術的種類及日期	Type of Surgery Treatment 手術的種類 Day 日 Month 月 Year 年
7. Type & Date of Non-Surgery Treatment 非手術的種類及日期	Type of Non-Surgery Treatment 非手術治療的種類 Day 日 Month 月 Year 年

8. Is there any evidence of permanent neurological damage? 有否永久性神經機能缺損的跡象？ If yes, please provide details below. 如有，請提供詳情。	○ Yes 是 ○ No 否
9. 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？ If yes, please provide details below. 如有，請提供詳情。	○ Yes 是 ○ No 否
10. Has the Insured previously suffered from this illness or any related conditions? 受保人是否有同類之病史？ 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。	○ Yes 是 ◉ No 否 The resulting diagnosis 詳細診斷結果 Day 日 Month 月 Year 年
11. 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: _____
12. 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: _____
13. 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: _____
14. Please indicate if the illness is associated with the followings: 請說明該疾病是否與下列情況有關：	☐ Congenital disease 先天性疾病 ☐ Under the influence of drugs or alcohol 受酒精或藥物影響 ☐ AIDS or HIV Infection or related surgeries 愛滋病或人體免疫力缺乏病毒感染導致的疾病或手術 ☐ Self-inflicted injuries or suicide 自我損傷或自殺行為 ☐ None of the above 不是上述任何一個
15. 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。	
16. 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。	

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

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。

Signature and official chop 簽署及蓋印

Day 日 Month 月 Year 年

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