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：

Loss of Independent Existence

The permanent inability of the insured to perform without the continual assistance of another person, 3 or more of the following activities of daily living:

- Washing – the ability to wash in a bath or shower (including getting into and out of the bath or shower) or to wash satisfactorily by other means.
- Dressing – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.
- Feeding – the ability to feed oneself once food has been prepared and made available.
- Toileting – the ability to use the lavatory or otherwise manage bowel and bladder function so as to maintain a satisfactory level of personal hygiene.
- Transferring – the ability to move from a bed to an upright chair or wheelchair and vice versa.

The coverage of this benefit will commence at age 18 and cease at age 65. Your benefit does not cover any event caused by a psychiatric Condition

失去獨立生活能力

受保人在沒有他人長期輔助的情況下，永久地喪失進行下列3項或以上的日常活動能力：

- 梳洗 — 於浴缸洗澡或淋浴（包括進出浴缸或淋浴室）的能力或以其他方式滿意及合理地完成梳洗。
- 穿衣 — 穿上、脫下、繫緊或鬆開各種衣服或任何適當的支架、義肢或其他外科器具的能力。
- 進食 — 當食物準備好時，自己進食的能力。
- 如廁 — 使用洗手間或控制大小便，以保持滿意的個人衛生的能力。
- 移動 — 從床移動到直背椅子或輪椅上的能力，及從椅子或輪椅移動到床的能力。

本保障計劃承保範圍由18歲開始至年屆65歲時終止， 閣下的保障不包括任何因精神科引起的情況。

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 從 |______|______|______| (DD/MM/YY) 日/月/年 OR 或 for 已存在 ______day(s) 日 ______ month(s) 月 ______year(s) 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) 日/月/年 By (name & address of physician): 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?

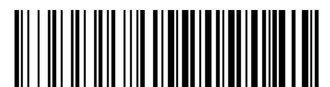
5. (a) **Final diagnosis 最後診斷**

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



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. Is the patient able to perform the followings without continual assistance? 病人在沒有持續協助的情況下能否進行下列活動?

(a) Washing (wash in a bath or shower)
梳洗 (於浴缸洗澡或淋浴)
❐ Able 能夠 ❐ Unable 不能夠
Reason 原因:
Asistance required 所需要的協助:

(b) Dressing (put on, take off, secure and unfasten all garments, any braces, artificial limbs or other surgical appliances , as appropriate)
穿衣 (穿上、脫下、繫緊或鬆開各種衣服或任何適當的支架、義肢或其他外科器具)
❐ Able 能夠 ❐ Unable 不能夠
Reason 原因:
Asistance required 所需要的協助:

(c) Feeding (feed oneself once food has been prepared and made available)
進食 (當食物準備好時，自己進食)
❐ Able 能夠 ❐ Unable 不能夠
Reason 原因:
Asistance required 所需要的協助:

(d) Toileting (use the lavatory or otherwise manage bowel and bladder function)
如廁 (使用洗手間或控制大小便)
❐ Able 能夠 ❐ Unable 不能夠
Reason 原因:
Asistance required 所需要的協助:

(e) Transferring (move from a bed to an upright chair or wheelchair and vice versa)
移動 (從床移動到直背椅子或輪椅上，及從椅子或輪椅移動到床)
❐ Able 能夠 ❐ Unable 不能夠
Reason 原因:
Asistance required 所需要的協助:

13. What is/are the underlying cause(s) leading to this condition? 什麼原因引致的病人的情況?

14. 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

15. 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

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

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

Name of Physician ____________________
醫生姓名

Qualification ____________________
資歷

Hospital Name (if applicable) ____________________
醫院名稱(如適用)

Telephone No.____________________
聯絡電話

Address____________________
地址

Signature & Hospital/ Physician's Chop ____________________
醫院/ 醫生簽署及蓋印

Date (DD/MM/YY) ____________________
日期 (日/月/年)