



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 "Heart Attack" 適用於「心臟病發作」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。

1. Name of the Patient (Insured) 病人(受保人)姓名		2. HKID Card / Passport No. 香港身份證 / 護照號碼	
3. Details of the consultation for current illness 是次疾病的詳情	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)
	Diagnostic test performed & result 確診測試及結果	_____	
Previously treated for same/related disorder? 是否曾因同類或相關疾病接受治療?	<input type="checkbox"/> Yes (please provide details) 是 (請提供詳情) <input type="checkbox"/> No 否		
4. 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?	<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? 住院期間是否有進行手術?	<input type="checkbox"/> Yes (please provide details) 是 (請提供詳情) <input type="checkbox"/> No 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>5. Had the patient previously referred by other physician? 病人是否經其他醫生轉介？</p>	<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>															
<p>6. Details of the heart attack 有關心臟病發作詳情</p>	<p>Date of attack _____ (dd/mm/yyyy) 發作日期 _____ (日/月/年)</p> <p>Duration of the acute symptom _____ 急性徵狀持續時期 _____</p> <p>Was there a history of typical chest pain? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 是否有典型的胸痛病歷？</p> <p>Were there any new characteristic changes in ECG indicative of myocardial infarction? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 於心臟事故期間心電圖是否顯示新近具急性心肌梗塞特徵的變化？</p> <p>Have any Echocardiographic been performed prior to this infarct? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 於心臟事故期間是否曾作心臟超聲波檢查？</p> <p>If yes, please provide details (including date & result) and attach copies of report. 若是，請提供詳情 (包括日期及結果)，並附上有關測試報告副本。</p> <p>_____</p> <p>_____</p> <p>Was the test of cardiac enzymes CPK-MB or cardiac troponin T or I performed? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 是否有進行心肌酵素 CPK-MB 或心肌旋轉蛋白 T 或 I 的測試？</p> <p>If yes, please provide details (including date, type of test performed and result) and attach report copies. 若是，請提供詳情 (包括測試日期、種類及結果)，並附上有關測試報告副本。</p> <p>_____</p> <p>_____</p> <p>Was there death of a portion of heart muscle? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 是否有部份的心肌壞死？</p> <p>What is the degree of permanent physical impairment of heart muscle function based on New York Heart Association (NYHA) classification? 根據紐約心臟協會指引，心肌功能永久性損害達到什麼級別？</p> <p>_____</p> <p>Was the permanent physical impairment of heart muscle function last for six months or above continuously? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 心肌功能永久性身體損傷是否持續六個月或以上？</p>															
<p>7. 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。</p> <p>Please enclose copies of all the test reports. 請附上所有檢驗報告。</p>	<table border="1"> <thead> <tr> <th>Date of Test 檢驗日期</th> <th>Test Item 檢驗項目</th> <th>Result 結果</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Date of Test 檢驗日期	Test Item 檢驗項目	Result 結果	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
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<p>8. 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風險？</p>	<p><input type="checkbox"/> Yes (please provide details) 是 (請提供詳情) <input type="checkbox"/> No 否</p>															
<p>9. 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>	<p><input type="checkbox"/> Yes (please provide details) 是 (請提供詳情) <input type="checkbox"/> No 否</p> <p><input type="checkbox"/> Smoking 吸煙 <input type="checkbox"/> Drinking 飲酒 <input type="checkbox"/> Drug taking 服用藥物</p> <p>Duration _____ Consumption per day _____ 持續時間 _____ 每天用量 _____</p>															

<p>10. 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、慢性或先天性疾病？</p>	<p><input type="checkbox"/> Yes (please provide details) 是 (請提供詳情) <input type="checkbox"/> No 否</p>																
<p>11. Please list details of all medical history (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歷詳情 (除上述已提及外)。</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Consultation date 求診日期</th> <th style="width: 25%;">Complaints/Symptoms 主訴 / 病徵</th> <th style="width: 25%;">Diagnosis 確診</th> <th style="width: 25%;">Treatment given 所提供治療</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Consultation date 求診日期	Complaints/Symptoms 主訴 / 病徵	Diagnosis 確診	Treatment given 所提供治療	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
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_____	_____	_____	_____														
<p>12. 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>	<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>																
<p>13. Have the biological parents or siblings of the patient been diagnosed prior to age 60 with any of the illnesses listed in the right side? 請問病人的親生父母或兄弟姐妹在六十歲之前有否患有右列之疾病？</p>	<p><input type="checkbox"/> Yes (please check appropriate and give details) 是 (請選擇適當情況及提供詳情) <input type="checkbox"/> No 否</p> <p><input type="checkbox"/> Cancer 癌症</p> <p><input type="checkbox"/> Heart disease 心臟病</p> <p><input type="checkbox"/> Stroke 中風</p> <p><input type="checkbox"/> Diabetes 糖尿病</p> <p><input type="checkbox"/> Alzheimer's Disease 阿茲海默症</p> <p><input type="checkbox"/> Parkinson's Disease 帕金森病</p> <p><input type="checkbox"/> Polycystic Kidney Disease 多囊性腎病</p> <p><input type="checkbox"/> Other inherited disease or disorder 其他遺傳性疾病</p> <p>Please provide details 請提供詳情</p> <p>_____</p>																
<p>14. Any additional information you consider relevant to this claim. 其他與是次索償有關的資料。</p>																	

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 in block letters 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)