

危疾賠償申請表-良性腦腫瘤 CRITICAL ILLNESS CLAIM FORM – BENIGN BRAIN TUMOUR

		保車號碼 Policy No.											
第二部份 - 主診醫生報告書 (由主診醫生填寫·所有費用由受保人/保單持有人/索償人自行承擔) PART II - ATTENDING PHYSICIAN'S STATEMENT (To be completed by attending physician at the Insured / Policyholder / Claimant's own expenses.)													
A. 病人資料 PARTICULARS OF PATIENT													
1	病人姓名 Name of Patient												
2	年齡及性別 Age and Sex												
3	身份證/ 護照號碼 I.D. Card / Passport No.												
B. 臨床資料 CLINICAL DETAILS													
1	病人之醫療記錄可追溯至 We can trace the me	edical record of patient back t	to										
	年 Year 月 Month	日 Day 											
2	首次出現病徵日期發生日期 Date of the symp	toms first appeared											
	年 Year 月 Month	⊟ Day											
3	病人首次有關此病症之求診日期 Date of first	consultation for this condition	n or re	lated il	Iness								
	年 Year 月 Month	⊟ Day											
4	請詳細說明首次會診時之徵狀和病症 Please	describe the symptoms and	compla	ints at	first c	onsult	ation.						
5	病人是否由其他醫生轉介?如是,請提供	該醫生之姓名及地址。Is	the pa	tient r	eferred	l by o	ther	是	Yes		否No)	
	physician? If yes, please give the name and add	ress of the referring doctor.											
6	診斷 Diagnosis												
7	何時確診 When was the diagnosis made	年	Year	ı	ı	1	月 Mo	nth	ı	日 Day	/		
C. [閣下之專業意見 PROFESSIONAL COMMEN	Т											
1	腫瘤是否已完全或部分以外科手術切除 Has	s the tumour been totally or pa	artially	surgic	ally era	adicate	ed?						
	□是·請詳述組織學結果 Yes, please provide detail of histology results □不是 No												
2	病人的腦腫瘤是什麼類型?是否屬於癌症?	請說明及提供有關的病理	組織報	告作釒	参考								
	What type of brain tumour does the patient have? Cancerous or Non-cancerous? Please specify and provide pathological report for reference.										ence.		



中國人壽保險(海外)股份有限公司(於中華人民共和國註冊成立之股份有限公司) China Life Insurance (Overseas) Company Limited (incorporated in the People's Republic of China with limited liability) HK-CL-ICLA29/202412-01 P. 1 of 2

					保單號	虎碼 Policy N	No.												
C.	引下之:	專業意見(網	賣) PROFE	SSIONAL COM	MENT (C	ontinued)													
3 延續上述第 2 題·該腦腫瘤是否屬於以下的類別?																			
	In addition to its classification stated in Question 2, does the brain tumour belong to any of the followings:																		
	(a)	囊腫																	
	(b)										是 Yes			不是 No					
	(c)	腦動脈或靜	脈畸形	Malformatio	on in, or o	f, the arteries o	of veins	or the	brain		是 Yes			不是 No					
	(d)	血腫		Haematoma			是 Yes			不是 No									
	(e)	腦垂體或資	作 種瘤	Tumours in		□是 Yes □不是 No													
	(f)	聽覺神經腫	瘤	Tumours of		□是 Yes □不是 No													
4	4 病人現時進展及狀況? What was the prognosis of the patient?																		
_	#□ ≠=	生 担 从 士 胆 目	3-5公庙		ナズバ	(司/共2%)☆ ユリ	山 700 公4 -	÷∧	\ 	د د خ⊥ ا	1 161					4:4:			
5 如有,請提供有關是次治療、檢查及其結果、有否任何併發症及出院後之覆診或跟進計劃 If so, please provide treatments, investigation procedures, results, and/or any complications and follow up plan regarding the stroke)																			
	procedures, results, and/or any complications and follow up plan regarding the stroke)																		
D. 享	地醫 鄉	寮病史 OTH	ER MEDIC	AL HISTORY															
1	病人達	過往有否以下	病症/習情	貫 ∘ Does the pati	ient have	any medical hi	istory o	r habit	as inc	licated	below?								
	1 病人過往有否以下病症/習慣。 Does the patient have any medical history or habit as indicated below? ☐ 哮喘 Asthma ☐ 心臟病 Cardiac problem ☐ 糖尿病 Diabetes Mellitus																		
	□ 乙型肝炎 Hepatitis B □ 高血壓 Hypertension □ 曾接受手術 Previous operation																		
	□ 濫藥 Drug abuse □ 飲酒習慣 Drinking □ 吸煙習慣 Smoking																		
	□ 家族性癌症 Family history of cancer □ 家族病史 Unfavorable family history																		
以上皆沒有 None																			
U 以工質沒有 None L 具他疾病,讀說明 Other disease, please specify																			
2									請延	誀情 [。]	Had the	e pat	ient prev	iously beer	ı trea	ated or			
hospitalized for the above disease or other major dise						治療/住院詳情						醫生姓名/醫院名稱							
年 Ye	¥ Year │月 Month │日 Day 疾病 Disease					Details of treatment/hospitalization							Name of Physician/Hospital						
2	<u>‡±+₽/-</u>	比约:ボ/瓜城	13 사물 ≐감 사丰 I	Olagaa waayida da	taile of D	nimbina 9 Cma	kina ha	L:4											
3				Please provide de	talls of D	rinking & Smo	_				_	3 Mau	.41.	□ D •					
	習慣始自 Drinking/ Smoking start date since 年 Year 月 Month 日 Day																		
	每日用量 Daily consumption (支/包/樽/罐 piece/ pack/ bottle/ can)																		
c -1	- 言念 医殳 A	十多料工設	OB ATTEN	DING PHYSICIA	ANIC DAT	OTICIII ADC A	ND DE		O A T I O	NI									
											DC that al	II tha is	oformation.	provided by m	in 4	hia farm ia			
本人謹此聲明·就本人所知所信·上述由本人提供的資料均為事實之全部·並確實無訛。I HEREBY DECLARE that all the information provided by me in this form is true and correct to the best of my knowledge and belief.												nis torm is							
主診醫生姓名									j	資歷									
Name of Attending physician								-	Qualific	ation									
地址 Address								J	聯絡電話										
										Contact No.									
‡診	醫牛 簽	署及緊赔/	诊所 萎音									í	∓ Year	月 Month		⊟ Day			
主診醫生簽署及醫院/診所蓋章 Signature of Attending Physician and								日期											
Stamp of Hospital / Clinic							Date												