AIA International Limited
(Incorporated in Bermuda
with limited liability)

CONFIDENTIAL MEDICAL CERTIFICATE – 醫生報告

PART II - To be completed by doctor at Insured's/Claimant's expense 第二部份（受保人或申請人自費由主診醫生填寫）

Policy No. 保單號碼	
Name of Insured 受保人姓名	ID Card/Passport No. 身分證/護照號碼

CRITICAL ILLNESS – AUTISM
危疾 – 自閉症

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？

☐Yes 是 ☐No 否

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？

(/ /) MM/DD/YYYY 月/日/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。

(/ /) MM/DD/YYYY 月/日/年

What were the symptoms? 受保人之病徵。

_____

How long had the symptoms been presented? 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 dates of consultations and the resulting diagnosis. 如 "有"，請提供求診日期及診斷詳細結果。

_____

4. Has Autism been definitely diagnosed? 自閉症之診斷有否被確認?

☐Yes 有 ☐No 沒有

On which date was the diagnosis made? 有關疾病之診斷是何時首次確認?

(/ /) MM/DD/YYYY 月/日/年

Was the diagnosis confirmed by a registered pediatric psychiatrist? 該疾病是否由兒童精神專科醫生確定?

☐Yes 是 ☐No 否

Please give the Name and Address of the pediatric psychiatrist if it is not the undersigned. 若非由填寫此表格之醫生確認，請提供兒童精神專科醫生之姓名及地址。

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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

6. Other physicians or medical facilities the insured has consulted for this condition 受保人曾經因此病而就診之其他醫生姓名或醫院名稱及地址。

Name of physician/facility 醫生姓名或醫院名稱	Address 地址	Date of consultation/confinement period (MM/DD/YYYY) 求診日期 / 住院時段（月/日/年）

Details of "Yes" answers. (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities).
如答 "是"，請提供診斷結果、日期、病徵持續時期及主診醫生姓名、醫療機 構名稱及地址等資料。

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7. Please describe the extent of the disease. 請描述該病之狀況。

i. Date of onset 病發日期：(/ /) MM/DD/YYYY 月/日/年

ii. Has the Autistic conditions continuously existed for at least 6 months after the diagnosis was made? 自閉症行為是否在診斷後持續出現至少 6 個月?

☐ Yes 是 ☐ No 否

If yes, how long has the condition been medically documented? 如是，上述病症約存在了多久?

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iii. Is the insured undergoing behavioral therapy, occupational therapy, speech therapy, psychological interventions or special education at a recognized institute for autistic children? 受保人是否在為自閉症兒童而設的認可學校內接受行為治療、職業治療、語言治療、心理介入治療或特殊教育?

☐ Yes 是 ☐ No 否

If yes, since when did the insured receive special education at the institute? 如是，受保人由何時開始接受特殊教育?

(/ /) MM/DD/YYYY 月/日/年

Therapy Received 接受之治療: _____

Name of Institute 機構名稱: _____

iv. Based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which of the following diagnostic criteria are met? 根據精神疾病診斷及統計手冊 (DSM-5)，受保人符合以下哪些條件?

a. Persistent deficits in social communication and social interaction across multiple contexts 在多種環境下長期缺乏社交溝通及社交互動能力	☐Yes 是	☐No 否
b. Severe deficits in verbal and nonverbal social communication skills causing severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others 言語及非言語的社交溝通技巧嚴重不足，導致功能上嚴重缺陷，在社交互動中作出非常有限度的主動及對其他人的社交友好表示作出最小的回應	☐Yes 是	☐No 否
c. Restricted, repetitive patterns of behavior, interests, or activities 限制性、重復性的行為、興趣或活動	☐Yes 是	☐No 否
d. Inflexibility of behavior, extreme difficulty coping with change, or other restricted /repetitive behaviors that markedly interfere with functioning in all spheres 行為缺乏彈性、極度難於適應改變，或作出有限制性/重復性的行為，嚴重妨礙各種領域的功能發揮	☐Yes 是	☐No 否
e. Great distress / difficulty in changing focus or action 對改變焦點或行為時表示極度憂慮及困難	☐Yes 是	☐No 否
f. Symptoms are present in the early developmental period 症狀在早期發展階段出現	☐Yes 是	☐No 否
g. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning 症狀對社交、職業或其他重要範圍的現有功能在臨床上造成重要損害	☐Yes 是	☐No 否

If any of the above criteria is met, please provide details. 如符合上述任何一項條件，請提供詳情。

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v. Was/were the above condition(s) certified by the insured's treating pediatric psychiatrist? 上述情況是否由受保人的兒童精神專科醫生證實?

☐ Yes 是 ☐ No 否

Please give the Name and Address of the pediatric psychiatrist if it is not the undersigned. 若非由填寫此表格之醫生確認，請提供兒童精神專科醫生之姓名及地址。

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8. Please enclose copies of all reports including laboratory evidence, psychological testing, etc. and any relevant hospital reports that are available. 請提供所有報告包括化驗報告、心理評估報告等，或任何有關的醫院報告。

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9. 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。

10. 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 hereby declare that the information given on this form is true and complete to the best of my/our knowledge and belief.
本人/我們現聲明此申請書上所填資料皆為本人/我們所知及所信之事實及其全部。

PERSONAL DATA COLLECTION AND USE

PLEASE READ THE AIA PERSONAL INFORMATION COLLECTION STATEMENT ("AIA PIC") BEFORE YOU SIGN THIS CERTIFICATE. IF THE AIA PIC STATEMENT IS NOT ATTACHED, YOU CAN ASK FOR A COPY FROM US. Also, the updated version of AIA PIC is available for download from its website: www.aia.com.hk.

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

個人資料收集及使用

簽署此醫生報告前，**請先閱讀 AIA 個人資料收集聲明。** 如 AIA 個人資料收集聲明未有隨附於本醫生報告，閣下可向我們索取複印本一份。 AIA 個人資料收集聲明的最新版本亦可於以下網址下載：www.aia.com.hk。

所有個人及其他於此醫生報告收集所得的任何資料將會被我們用作處理受保人之索償申請，我們亦可根據 AIA 個人資料收集聲明使用該些資料。 向閣下提出要求填寫此醫生報告即表示受保人/保單持有人已授權閣下可於此報告透露他/她的個人資料及其他資料給我們。

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

Signature and official chop 簽署及蓋印

Address and telephone number 地址及聯絡電話

Date 日期