Manulife 宏利

CLAIM FORM
FOR MAJOR DISEASE - STROKE
重病保障索償表格 — 中 風

Policy No.
保單編號 : _____

PART II – This Attending Physician's Statement must be completed by a qualified and registered physician at the insured's expense
第二部份 — 本應診醫生報告必須由受保人自費聘請之合資格註冊醫生填寫

1. Name of Patient 病人姓名	2. I.D. Card No. 身份證號碼	3. Age 年齡

4. Are you the patient's usual medical attendant? 閣下是否病人之私人醫生?
☐ No 否 ☐ Yes 是 If "Yes", give details 若「是」,請填寫有關資料。

Period of Consultation 應診期間 | Past Health History 病人過往健康情況

5. a) Date on which you first attended the patient for this disease (Stroke). 首次為病人診治是項病症(中風)之日期。

b) How long do you believe the symptoms had been present when you were first consulted? 於首次診治主要時,閣下相信病徵已出現了多久?

c) When was the patient informed of the diagnosis? (Please give exact date) 何時通知病人診斷結果?(請填寫準確日期)

6. Give full and exact details of the diagnosis. 請詳盡填寫確實診斷資料。

7. Had the patient any past history of the disease specified above or related illness? 病人過往曾否患有上述疾病或有關疾病?
☐ No 否 ☐ Yes 有 If "Yes", give details 若「有」,請填寫有關資料。

Name of Attended Physician(s) 應診醫生姓名	Date of Consultation 診治日期	Address(es) 地址	Exact Diagnosis 確實診斷資料

8. Is there anything in the patient's family history which would have increased the risk of Stroke? 病人之家庭背景有否任何增加病人患上中風機會之事項?

9. Please give details of the patient's habits in relation to alcohol, drugs and smoking. 請填寫病人飲酒、吸毒或吸煙習慣之詳情。

10. a) Please decribe the initial episode: 請指出病發初期情況:
clinical events 臨床情況

b) Duration of acute symptoms 急性病徵出現時間

c) Date of return to normal activities and/or the patient's persent limitations-Physical and mental 恢復從事正常活動之日期及/或病人現時之身體及精神限制

11. Please comment on any neurological sequelae which lasted more than 24 hours. Are these sequelae permanent? 請解釋為時二十四小時以上之神經系統後遺症。該後遺症會否永久存在?

12. Has there been an intarction of brain tissue, haemorrhage or embolisation from an extra-cranial source? 曾否出現腦組織梗塞、出血及其他頭顱以外的血管根源引致之腦栓塞?
☐ Yes 有 ☐ No否

13. Please supply details of radiological investigations and laboratory evidence as well as any other tests. 請提供有關放射性檢查、化驗證明及其他檢查之資料。

14. Please provide details of physicians to whom the patient has been referred or attended for this disease. 請提供曾為病人診治是項病症之醫生資料。
(We would be grateful for copies of any relevant medical report that are available) (敬請提供任何有關醫療報告副本)

Name of Physician(s) and/or Hospital(s) 醫生姓名及/或醫院名稱	Address(es) 地址	Date of Consultation(s) and/or Period of Confinement(s) 診治及/或留院日期

15. If there is any further information which, in your opinion, will assist us in assessing this claim, please furnish such information below.
閣下認為有否其他資料可協助本公司審核是項索償申請?請提供有關資料。

Signature 簽署 X _____ Name of Physician (with stamp) 醫生姓名(連印章) _____

Date 日期 _____ Address 地址 _____

Qualification 資格 _____ Tel. No. 電話號碼 _____