Manulife 宏利

Policy No.
保單編號：

CLAIM FORM FOR MAJOR DISEASE - CANCER
重病保障索償表格 － 癌 症

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 (DD/MM/YYYY) 應診期間(日/月/年)	Past Health History 病人過往健康情況

5. a) Date on which you first attended the patient for this disease (Cancer). 首次為病人診治是項病症（癌症）之日期。 (DD日/MM月/YYYY年)

b) How long had the patient been experiencing the symptoms/complaints before the first consultation? 病人在首次求診前已患有症狀／主訴多久？(DD日/MM月/YYYY年)

c) Symptoms (s) / complaint(s) of the patient relating to this disease (cancer) 病人就是項病症(癌病)所出現的症狀/主訴

d) 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）(DD日/MM月/YYYY年)

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 是 If "Yes", give details 若「有」，請填寫確實診斷資料。

Name of Attended Physician(s) and /or Hospital(s) 應診醫生姓名及/或醫院名稱	Date of Consultation (DD/MM/YYYY) 診治日期(日/月/年)	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 Cancer? 病人之家庭背景有否任何增加病人患上癌症機會之事項？

☐ No 否 ☐ Yes 有 If "Yes ", give details 若「有」，請填寫有關資料。

9. Did or does the patient have any habits in relation to drinking, drug taking and smoking. 病人是否或曾有飲酒、吸毒或吸煙之習慣？

	Duration 持續時間 From 由 (DD日/MM月/YYYY年)	To 至 (DD日/MM月/YYYY年)	Consumption Per Day 每天用量：
a) Drinking 飲酒 ☐ No 否 ☐ Yes是			
b) Drug taking 吸毒 ☐ No 否 ☐ Yes是			
c) Smoking 吸煙 ☐ No 否 ☐ Yes是			

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10.a) What was the site or organ involved and the precise histology of the tumor? 請填寫腫瘤所處之位置或受影響之器官，及詳列腫瘤之組織結構?

b) What tests were performed to confirm the diagnosis? 進行了哪些測試來確認此診斷？

Date of the Test 檢驗日期 (DD日/MM月/YYYY年)	Test item 檢驗項目	Result 結果

c) What was the staging system used? 腫瘤之分期系統?

(For **cancer**, pleases state stage under the American Joint Committee on Cancer (AJCC) cancer staging system; for **brain tumour**, please state stage under World Health Organization Classification of Tumours; for **Hodgkin lymphoma or Non-Hodgkin lymphoma**, please state stage under the Lugano classification; for **chronic lymphocytic leukaemia**, please stage the Rai stage)
(如屬**癌症**，請根據美國癌症聯合委員會 (American Joint Committee on Cancer) 癌症分期系統分類列出其級別 ;如屬**腦腫瘤**，請根據世界衛生組織腫瘤分類 (WHO Classification of Tumours) 列出其級別) ; 如屬**何傑金淋巴瘤或非何傑金淋巴瘤**，請根據盧加諾分期法 (Lugano Classification) 列出其級別; **如屬慢性淋巴球白血**˄**病**，請列出其Rai級別)

d) Based on above staging system, what is the staging of the tumour? 根據以上分期系統，該腫瘤為第幾級別?

e)	Is the disease completely localized? 病症是否完全局部化？	☐ No 否	☐ Yes是
f)	Is there uncontrolled growth and spread of malignant cells? 癌細胞是否不受控制地生長及擴散？	☐ No 否	☐ Yes是
g)	Is there an invasion and destruction of adjacent tissue by malignant cells? 癌細胞是否侵入和破壞鄰近細胞組織？	☐ No 否	☐ Yes是
h)	Are regional lymph nodes involved? 是否影響鄰近淋巴結？	☐ No 否	☐ Yes是
i)	Are there distant metastases? 是否距離性轉移？	☐ No 否	☐ Yes是

11. 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) (DD/MM/YYYY) 診治及/ 或留院日期(日/月/年)

12. What kind of treatment(s) is/are the patient receiving/had the patient received? 病人正/ 曾接受什麼治療?

Treatment 治療	Please list out the treatment dates, period, schedule and details of treatments 請列出治療日期、期間、時間表和治療詳情 (DD日/MM月/YY年)
☐ Surgery 手術	
☐ Radiotherapy 電療	
☐ Chemotherapy 化療	
☐ Targeted therapy 標靶治療	
☐ Bone marrow transplant 骨髓移植	
☐ Proton therapy 質子治療	
☐ Immunotherapy 免疫治療	
☐ Cyber knife 數碼導航刀	
☐ Gamma knife 伽瑪刀	
☐ CAR-T cell infusion 嵌合抗原受體T細胞(CAR-T) 細胞滴注	
☐ Hyperthermia therapy 高溫熱療	
☐ Photodynamic therapy (PDT) 光動力療法(PDT)	
☐ Stem cell therapy 幹細胞治療	
☐ Clinical trial cancer drug treatment 臨床試驗癌症藥物治療*	
☐ Off-label cancer drug treatment 非適應症癌症藥物治療*	
☐ Others, please specify 其他，請註明:	

* Please answer question 14 if patient is receiving/had received Clinical Trial Cancer Drug Treatment and/or Off-label Cancer Treatment 如病人正/ 曾接受「臨床試驗癌症藥物治療」及/或「非適應症癌症藥物治療」，請回答問題14

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13. Is the patient receiving End-of-life Care treatment? (ie. any treatment provided in hospital or a registered hospice specifically to relieve cancer symptoms in which the cancer is progressing due to lack of treatment to cure or control the cancer) 病人是否正接受晚期護理? (即在醫院或註冊善終院舍接受舒緩癌症症狀之治療，而該癌症正在惡化且未有醫治或控制該癌症的治療方法)

☐ No 否 ☐ Yes 是 If "Yes ", please advise details of previous treatments given, current situation, prognosis and periods that the patient receives End-of-life Care treatment 若是，請就曾提供的治療、現時情況、預後及病人接受晚期護理治療的時段提供更多詳情

14. If patient is receiving/had received Clinical Trial Cancer Drug Treatment and/ or Off-label Cancer Drug Treatment, please provide the following documents. 如病人正/ 曾接受「臨床試驗癌症藥物治療」及/或「非適應症癌症藥物治療」，請提供以下文件:

- Medical journal 醫學文獻
- Clinical practice guidelines or protocol stipulated by a medical institution 醫療機構規定的臨床實踐指南或方案
- Drug insert 藥物說明書

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。

Name of Physician (with stamp) 醫生姓名（連印章）

X
Signature 簽署

Qualification of Physician 醫生資格

Date 日期 (DD日/MM月/YYYY年)

Address 地址

Tel. No. 電話號碼