

CLAIM FORM FOR MAJOR DISEASE - KIDNEY FAILURE 重病保障索償表格 — 腎衰竭

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? <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是 If "Yes", give details 若「是」, 請填寫有關資料。 <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>Period of Consultation</u> 應診期間 </div> <div style="width: 45%;"> <u>Past Health History</u> 病人過往健康情況 </div> </div>		
5. a) Date on which you first attended the patient for this disease (Kidney Failure).首次為病人診治是項病症(腎衰竭)之日期。 b) How long do you believe the symptoms had been present when you were first consulted?於首次診治時, 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? <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 有 If "Yes", give details 若「有」, 請填寫有關資料。 <div style="display: flex; justify-content: space-between;"> <div style="width: 25%;"> <u>Name of Attended Physician(s)</u> 應診醫生姓名 </div> <div style="width: 20%;"> <u>Date of Consultation</u> 診治日期 </div> <div style="width: 20%;"> <u>Address(es)</u> 地址 </div> <div style="width: 35%;"> <u>Exact Diagnosis</u> 確實診斷資料 </div> </div>		
8. Is there anything in the patient's family history which would have increased the risk of Kidney Failure? 病人之家庭背景有否任何增加病人患上腎衰竭機會之事項?		
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. What is the underlying kidney disease causing renal failure? 導致腎衰竭之腎病是甚麼?		
11. Had the patient's renal disease reached end-stage? 病人之腎病是否已達末期階段?		
12. Is the patient currently undergoing regular peritoneal dialysis or haemodialysis? 病人是否現正接受定期腹膜透析或血液透析治療?		
13. Has renal transplantation been scheduled or performed? 是否已安排或已進行換腎手術? If yes, please give the date. 若「是」, 請填寫有關日期。		
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) <div style="display: flex; justify-content: space-between;"> <div style="width: 35%;"> <u>Name of Physician(s) and/or Hospital(s)</u> 醫生姓名及/ 或醫院名稱 </div> <div style="width: 20%;"> <u>Address(es)</u> 地址 </div> <div style="width: 45%;"> <u>Date of Consultation(s) and/or Period of Confinement(s)</u> 診治及/ 或留院日期 </div> </div>		
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。		
<div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> Signature 簽署 </div> <div style="width: 60%;"> Name of Physician (with stamp) 醫生姓名 (連印章) _____ </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 40%;"> Date 日期 _____ </div> <div style="width: 60%;"> Address 地址 _____ </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 40%;"> Qualification 資格 _____ </div> <div style="width: 60%;"> Tel. No. 電話號碼 _____ </div> </div>		