CRISIS COVER CLAIM FORM 危疾理賠申請書

Policy No. 保單號碼_____

Part II Medical Certificate (to be completed by the Attending Physician, at claimant's own expense) in relation to:

第二部份 - 醫療報告 (由索償人自費聘請主診註冊西醫填寫) 有關於:

Severe Rheumatoid Arthritis (Definition Before 2017)

Widespread joint destruction with major clinical deformity of 3 or more of the following joint areas: hands, wrists, elbows, spine, knees, ankles, feet. The diagnosis must be supported by all of the following:

- Morning stiffness
- · Symmetric arthritis
- · Presence of rheumatoid nodules
- · Elevated titres of rheumatoid factors
- · Radiographic evidence of severe involvement

The diagnosis must be confirmed by a Registered Specialist Rheumatologist.

嚴重類風濕關節炎 (二零一七年前的定義)

廣泛之關節破壞並有嚴重的臨床變形,影響下列最少3個主要關節:手、手腕、手肘、脊椎、膝、足踝、足。診斷須經下列各項證實:

- 清晨僵硬
- 對稱性關節炎
- 類風濕性小結顯露
- 類風濕因子滴定度上升
- 放射照相證實病情嚴重

診斷必須經由註冊風濕病科專科醫生證實。

Severe Rheumatoid Arthritis (Definition from 2017 onwards)

Severe Rheumatoid Arthritis where all of the following criteria are met:

- a) fulfill the diagnostic criteria of Rheumatoid Arthritis Classification by the American College of Rheumatology (ACR) as confirmed by a Registered Specialist Rheumatologist; and
- b) widespread joint destruction with major clinical deformity of 3 or more of the following areas: hands, wrists, elbows, spine, knees, ankles, feet; and
- c) permanent inability to perform, without assistance, two Activities of Daily Living; and
- d) persistent conditions of at least six months.

嚴重類風濕關節炎 (二零一七年起的定義)

嚴重類風濕關節炎必須符合以下所有標準:

- a) 由註冊風濕病科專科醫生證實符合美國風濕病學會 (就類風濕關節炎分類所界定之診斷準則;及
- b) 廣泛性關節損壞及下列之部位有三個或以上出現嚴重的臨床變形:手、手腕、手肘、脊椎、膝、足踝、足;及
- c) 在沒有協助的情況下永久失去進行兩項日常活動的能力;及
- d) 狀況已持續最少六個月。

Name of Patient 病人姓名	ID / Passport No. 身份證 / 護照號碼	Age & Sex 年齡及性別				
1. Are you the patient's usual physician? 你是否病人慣常求診的醫生?						
☐ Yes. Medical records dated back to 是,醫療紀錄可溯至	(DD/MM/YY) (日/月/年) □ No 2	下 是				
1 Too. Modical Toolida datod basis to 定 图示心系:1///工	(05/mm, 1) (1////+/ 13 He					
2. When were you first consulted for his/her illness(es)? 病人i	When were you first consulted for his/her illness(es)? 病人首次因相同或相關病症向閣下求診的日期?					
│ │	(DD/MM/YY) (日/月/年) Presenting signs & symptoms were 病徵包括:					
3. According to the patient, how long had he/she been experi 根據病人所提供的資料,病人在首次求診前,已經歷其病狀						
(成体的人) TIEDET EN A TOTAL TOTAL CONTROL OF THE ANALYSIS OF THE						
Since (DD/MM/YY) OR	Forday(s) month(s)year(s)					
後 (日/月/年) 或						
4. (a) Clinical diagnosis 臨床診斷						
(I) MIII						
(b) When was it made? 何時確診這診斷? (DD/MM/YY) (日/月/年)						
(c) When was the patient informed of the clinical diagnosis? 病人何時被醫生告知其所患的臨床病症及診斷?						
(DD/MM/YY) (日/月/年) by (name & address of physician) 由(醫生姓名及地址):						
(d) How long, in your opinion, has the patient suffered from this illness before his/ her first consultation?						
(以)外的 PD D D P PD D PD PD PD PD PD PD PD PD P						

5.	(a) Final diagnosis 最後診斷					
	(b) Date of final diagnosis 最終診斷日期	_ (DD/MM/YY) (日/月/年)				
	(c) Date the patient was informed of the diagnosis 病人被告知最	後診斷的日期為				
	(DD/MM/YY) (日/月/年) By (name	& address of physician) 由(醫	生姓名及地址):			
6.	Please provide full details of the diagnosis and its clnical basis.	請提供所有診斷及臨床診斷的	詳情			
7.	Was the patient refered to you from other physician(s)? 病人是?	下山甘仲毆先輔介 2				
	, , , , , , , , , , , , , , , , , , , ,	□ No 不是				
	By (name & address of physician) 由(醫生姓名及地址):					
8.	Has the patient ever been treated for the same/related condition					
0.	•	□ No 沒有	PRESTANTALITY .			
	Consultation Date (DD/MM/YY) Physician/ Hospital	Diagnosis	Treatment and Investigation Res	sults/ Hospitalization		
	就診日期 日/月/年 醫生/ 醫院全名	診斷	任何醫療診治及檢查結果/ 住院詩			
9.	Is there any patient's family history which would increase the risk	of the above final diagnosis?	?病人是否有任何既往家族病史而增加上	二述最終診斷的風險?		
	□ Yes, please provide details : 有,請詳述:			□ No 沒有		
10.	Does the patient smoke cigarette? 病人是否有吸煙習慣?					
	□ Yes, has been smoking since 有,由					
	□ Ex-smoker, started on 前吸煙者,開始於 ceased on 於 (DD/MM/YY) (日/月/年)					
	Ceased Off [S] (DD/WW/TT) (G/A/4-)	行业				
11.	 All consultations, specialists and hospitals to which your patient has been referred to or attended for this illness 病人因此病症而曾接受過診治的,或曾被轉介過的所有醫生 (普通科及專科) 和醫院名稱 					
	Consultation Date (DD/MM/YY)Physician/ Hospital就診日期日/月/年醫生/ 醫院全名	Diagnosis	Treatment and Investigation Resu 任何醫療診治及檢查結果/ 住院詳			
	州20万十 西江 西州土石	診斷	正问替尔砂/四次/ <u>城</u> 里和木/ 工机叶	IJA		
12.	If the final diagnosis is Rheumatoid Arthritis, what is the severity I	level (Mild. intermediate. seve	ere or others)?			
	若最終診斷為類風濕關節炎,請形容其嚴重程度(輕度、中度、嚴重	重或其他)。	,			
13.	Did the patient possess any of the followings? Please provide the 病人有否出現以下情況?如有,請附上顯示滴定度及放射學證據的		d titres and radiographic evidnce.			
	(a) Morning stiffness 清晨僵硬	☐ Yes, please pro	ovide details:有,請詳述:	■ No 沒有		
	(b) Symmetric arthritis 對稱性關節炎	☐ Yes, please pro	ovide details:有,請詳述:	□ No 沒有		
	(c) Presence of rheumatoid nodules 類風濕性小結顯露	☐ Yes, please pro	ovide details : 有,請詳述:	□ No 沒有		
	(d) Elevated titres of rheumatoid factors 類風濕因子滴定度上表		ovide details : 有,請詳述:	□ No 沒有		
	(e) Radiographic evidence of severe involvement 放射照相證	審住結器重 □ Voc. please pro				
	(o) Tradiographic oridones of covers involvement 0大对7州山西	頁的	ovide details: 有,請許娅:	□ No 沒有		

14 Does the nationt have clinical defa	ermity of the following joint area	as? If yes, please describe the severity of the	he condition of each involved joint				
病人以下的主要關節有否臨床變形			ne condition of each involved joint.				
例八以 11]工 女關印月 自	: XD: 月 , 明叶处台喇叭叫7安///1:	±/又 *					
(a) Hands 手	☐ Yes, please	provide details : 有,請詳述:	□ No 沒有				
(b) Wrists 手腕	☐ Yes, please	provide details : 有,請詳述:	□ No 沒有				
(c) Elbows 手肘	☐ Yes, please	provide details : 有,請詳述:	□ No 沒有				
(d) Spine 脊椎	☐ Yes, please	provide details : 有,請詳述:	□ No 沒有				
(e) Knees 膝	☐ Yes, please	provide details : 有,請詳述:	□ No 沒有				
(f) Ankles 足踝	☐ Yes, please p	provide details : 有,請詳述:	□ No 沒有				
(g) Feet 足	☐ Yes, please	provide details : 有,請詳述:	□ No 沒有				
, ,							
15. Does the patient have permanent 病人在沒有協助的情况下,是否永		sistance, two Activities of Daily Living (e.g.	dressing, bathing, toiletingetc)?				
□ Yes, please provide details		」(如才仅:////赤:如原…寻):					
1 res, piease provide details	· 足,明叶远。						
Inability of which two Activiti	ies of Daily Living? 失去那兩項	日常活動的能力?					
□ No 否							
4C Door the noticet have necessary	A conditions of local city mountly						
16. Does the patient have persistent conditions at least six months? 病人的狀況是否已持續最少六個月?							
□ Yes 是							
Duration 持續時間 (From 由: To 至:)							
□ No 否							
17. What tests were performed to confirm the diagnosis? (Please enclose copies of all laboratory reports and relevant medical reports that are available)							
有什麼檢驗結果讓閣下能確定此診	斷? (請提供檢驗報告及醫療報	告副本)					
Test Date (DD/MM/YY) 檢驗日期 日/月/年	<u>Test Item</u> 檢驗項目	<u>Diagnosis/ Result</u> 診斷/ 結果					
18. What is the prognosis of the patie	ent?病人現時進展及狀況						
	7137 (361372)6030000						
19. Other additional information for the	ne current diagnosis 其他有關/	土診斷结果之額外資料					
	3 1 1 7 1 7 1 7 1 7 1 7 1 7 1 7 1 7 1 7	SE STREET STORY					
Name of Attending Physician		Qualification					
主診醫生姓名		專業資格					
Hospital Name (if applicable) 醫院名稱(如適用)		 Telephone No 電話號碼					
agth 石(中) 电超频域							
地址							
Signature & Hospital/ Physician's Cho Signature & Hospital/ Physician's Cho	p	 Date (DD/MM/YY) 日期 (日/月/年)					