CHUBB®

# Living Benefit Claim - Stroke
# Part II - Attending Physician's Statement
(to be completed by attending physician at the claimant's own expenses)

# 生活保障賠償 - 中風
# 乙部 - 主診醫生報告 (由申請人自費，由主診醫生填寫)

Policy no. 保單編號 | | | | | | | | | | |

| Patient's name 病人姓名 | HKID Card/Passport no. 香港身份證/護照號碼 | Date of birth 出生日期 DD日 MM月 YYYY年 | Sex 性別 | Age 年齡 |
|---|---|---|---|---|
| | | / / | | |

**Stroke**

Any cerebrovascular incident producing neurological sequelae lasting more than twenty-four (24) hours and including infarction of brain tissue, haemorrhage and embolisation from an extracranial source. Evidence of permanent neurological damage must be confirmed by a Specialist in neurology at the earliest six (6) weeks after the incident and no claims can be admitted earlier. Cerebral symptoms due to migraine, cerebral injury resulting from trauma or hypoxia and vascular disease affecting the eye or optic nerve as well as ischaemic disorders of the vestibular system are excluded.

**中風**

任何大腦血管病變，包括腦組織梗塞、出血及由頭顱以外的根源引致的腦栓塞引致的神經系統後遺症，並必須持續最少二十四小時，並於病發後的六星期需由神經病科專家診斷證明受保人神經系統永久受傷害。偏頭痛、外傷或缺氧導致大腦受損、血管疾病影響眼部或視覺神經、前庭系統局部缺血等大腦症狀均除外。

## A. General Information 一般資料

1. Are you the patient's usual doctor? 閣下是否病人之慣常醫生? ☐ Yes 是 ☐ No 否
   Since when 自從 ( / / ) DD日 MM月 YYYY年
2. When were you first consulted for this illness? 病人就是次疾病首次向閣下求診之日期?
   ( / / ) DD日 MM月 YYYY年
3. What were the presenting symptoms? 請描述病人之病徵?
4. According to the patient, how long had the symptoms been present? 根據病人之描述，該病徵於何時出現?
   Since 自從 ( / / ) DD日 MM月 YYYY年 **OR或** for 已存在: years年 months月 days日
5. What were the significant physical findings? 請提供體檢結果或發現。
6. What was the exact diagnosis? 請提供診斷。
7. Date of diagnosis made? 診斷日期?
   ( / / ) DD日 MM月 YYYY年
8. When was the patient informed of the diagnosis? (Please give exact date) 病人於何時得悉上述診斷?（請提供日期）
   ( / / ) DD日 MM月 YYYY年
9. If you are not the first who diagnosed for this illness, please give name and address of the doctor who informed the patient of the diagnosis.
   若閣下不是首次確診病人上述診斷之醫生，請提供該醫生之姓名及地址。

10. Other physicians or medical facilities the patient has consulted for this condition. 病人就有關情況向其他醫生或醫療機構求診。

| Name of physician(s) &/or hospital(s) 醫生/醫院名稱 | Address(es) 地址 | Date of consultation(s) &/or period of confinement 求診日期及/或住院期 DD日 MM月 YYYY年 |
|---|---|---|
| | | ( / / ) To 至 ( / / ) |
| | | ( / / ) To 至 ( / / ) |
| | | ( / / ) To 至 ( / / ) |

## B. Extent of Illness 疾病程度

1. Please describe the initial episode : 請描述首次發作：
   a. Nature of episode 發作之性質

   b. Date of episode 發作之日期

   c. Duration of acute symptoms 急性症狀之持續時間

2. Has there been an infarction of brain tissue, haemorrhage and embolisation from an extra-cranial source?
   是否有腦組織梗塞、出血及由頭顱以外之根源引致之腦栓塞?
   ☐ Yes 是 ☐ No 否

3. Please comment on any neurological sequelae, which lasted more than 24 hours. If yes, please provide the details of such neurological sequelae.
   請詳述是否有任何持續超過二十四小時之神經系統後遺症。如是，請提供該神經系統後遺症之詳情。
   ☐ Yes 是 ☐ No 否

4. a. Are the neurological damages described above permanent?
   上述之神經系統是否有永久受傷害?
   ☐ Yes 是 ☐ No 否

   b. If yes, when and by whom are the neurological damages confirmed to be permanent?
   如是，何時及由誰確認神經系統有永久受傷害？
   i. When 何時：( / / ) DD日 MM月 YYYY年 ii. By whom 由誰：

   c. If no, please give date of return to normal activities and the patient's present limitation (both physically and mentally).
   如否，請提供恢復正常活動之日期及病人目前之限制(無論身體及精神上)。

5 . Is the condition of the patient 病人之狀況是否
   a. Cerebral symptom due to migraine? 因偏頭痛所引起之腦症狀?
   ☐ Yes 是 ☐ No 否

   b. Cerebral injury resulting from trauma or hypoxia? 外傷或缺氧導致大腦受損?
   ☐ Yes 是 ☐ No 否

   c. Vascular disease affecting eye or optic nerve? 血管疾病影響眼部或視覺神經?
   ☐ Yes 是 ☐ No 否

   d. Ischaemic disorders of the vestibular system? 前庭系統之缺血性失調?
   ☐ Yes 是 ☐ No 否

6. Has the patient previously suffered from the condition specified above or any related illness (e.g. hypertension, transient ischaemic attack, angina or other vascular disease)? If yes, please give dates of consultations and the exact diagnosis.
   病人以前是否患有上述疾病或任何相關疾病 (如高血壓、短暫性腦缺血發作、心絞痛或其他血管疾病)？ 如有，請提供求診日期及診斷名稱。

7. Is there anything in the patient's personal health history which would have increased the risk of stroke? Please give the details.
   病人之個人健康史中是否有任何增加患有中風之風險？ 請詳細說明。

8. In your opinion, does the condition suffered by the patient fulfil the definition stated?
   根據閣下之意見，病人之情況是否符合上述定義？

9. Please supply details of radiological, CT Scanning or NM imaging, and laboratory evidence as well as any other tests. (Please provide copies of the reports, if available)
   請提供放射學證據、電腦斷層掃描、核醫學顯像、實驗室證據以及任何其他測試報告。(請提供報告之副本，如有)

## C. Other Information 其他資料

1. Does the patient smoke cigarette or drink alcohol? If yes, please give details including the daily consumption and the duration of the habit.
   病人是否有吸煙或飲酒習慣? 若有，請提供詳情包括每天飲用或吸食之用量及該習慣之持續時間。
   ☐ Yes 是 ☐ No 否
   Quantity 數量 Type 類別 Duration 持續時間

2. Please state if the patient has suffered / been treated for any other illness(es) / complaints other than this critical illness.
   請說明病人是否曾經患有除此危疾以外之其他疾病或接受治療。

3. Is there any further information, which in your opinion will assist us in assessing this claim?
   請提供任何資料閣下認為可以幫助本公司審核此索償申請。

I hereby certify that I have personally examined and treated the patient for the above illness and that the facts as given above present my opinion of his/her conditions.
本人在此聲明，已向病人進行身體檢查，並對上述疾病進行治療及上述事實表明本人對上述病人之情況表述。

| Name of physician (with stamp)<br>醫生姓名（連印章） | Qualification<br>醫學資格 | Signature<br>簽署 | Date<br>日期 |
|---|---|---|---|

Address 地址：

Tel no.電話號碼:

Chubb. Insured.[SM]