

CHINA LIFE INSURANCE (OVERSEAS) CO. LTD.

Hong Kong Branch

中國人壽保險(海外)股份有限公司

香港分公司

Attending Physician's Statement For Accidental Permanent Disability

意外傷殘主診醫生證明書

Note: This statement should be fully completed and signed by Attending Physician. The expense must be paid by insured if necessary.

注意：本表須由受保人交予主診之註冊醫生填寫，並且保戶必須負責該表填寫費用。

Name of patient: 病人姓名	I.D.#: 身份證號碼	Age: 年齡	Sex: 性別	Occupation: 職業
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1. Date when you first saw the patient for this injury.
首次診治該病人日期

2. Please describe the symptoms and complaints of the patient during first consultation.
請詳細註明該病人於首次會診時之徵狀和病症?

3. Please describe the recent condition of the patient.
請詳細註明病人目前的傷情

4. To the best of your knowledge, if the accident caused permanent disability for the patient?
根據閣下的專業意見，是次意外是否導致該病人永久傷殘？

5. Please assess the loss of body function permanently caused by the injury, expressed by percentage.
請評估傷殘對身體功能所造成永久損失的程度（以%表示）

6. Please give details of all consultation and treatments given as far as your records go back.
請詳細記錄該病人所有就診及治療

Date 日期	Complaints & symptoms 主訴及症狀	Diagnosis 診斷	Type of treatments Given 治療措施	Duration of such Treatment 治療持續時間
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7. Results of investigation such as neurological examination, laboratory tests, X-ray, etc.
檢查結果例如神經科檢查、實驗室檢查、放射科檢查等

8. Is further Hospitalization / Surgery / Physiotherapy or other treatment necessary? If so, please specify.
是否需要進一步住院治療 / 外科手術 / 物理治療 / 或其他治療？若有，請詳述

9. Was the permanent disability caused from or effected by any of the following which may contribute to the permanent disability or lengthen the period of disability ? If yes, please specify.

下列原因是否引起或影響此次永久傷殘？如是，請詳述。

- (a) Physical defects / congenital anomaly (a) Yes:..... No
身體殘障／先天性疾病
- (b) Unfavourable past medical history (b) Yes:..... No
既往有不良健康史
- (c) Degenerative changes (c) Yes:..... No
退行性改變
- (d) Alcohol or drugs (d) Yes:..... No
酗酒或成癮藥物
- (e) Others, please specify
其他，請註明

10. Was the patient referred to you by another doctor ? If so, please indicate his/her name and address.

該病人是否由其他醫生推薦給你？若是，請註明醫生姓名及地址。

11. To the best of your knowledge, how the patient ever been treated for the same / related conditions or for any other serious disorders ? If so, please state when and the names of any other hospital(s) and /or doctor(s) attended.

根據您的專業知識，該病人是否因同一／相關病徵或其它嚴重疾病曾接受治療。若有，請詳述時間、醫院名稱／或醫生姓名

Dates 日期	Disease/Disorder 疾病／病徵	Details of treatment(s)/hospital(s) 詳細治療／住院記錄	Doctor's/Hospital's Name(s) 醫生／醫院名稱
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I hereby certify that I have personally examined and treated the insured in connection to the above disability and that the facts as given above present my opinion of his / her condition.

Name of physician:..... Signed:.....

Address:..... Date:.....

Qualification:..... Tele, No.:.....