ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง

Part III Details of Insured's Illness

ECIR-16	**BENIGN BRAIN TUMOUR**

1. Please describe the extent of the disease.

i. What is the Pathological diagnosis of the Tumor? _____

_____

ii. The location and extent of involvement _____

_____

_____

	YES	NO
iii. Is the tumor life threatening?	☐	☐
iv. Is tumor caused damage to the brain and permanent neurological deficit?	☐	☐

If 'YES', please describe. _____

_____

v. Has tumor caused permanent neurological deficit?	☐	☐

If 'YES', please describe. _____

_____

2. What is the nature of treatment?

☐ Surgical ☐ Gamma Knife ☐ Chemotherapy ☐ Radiotherapy ☐ Palliative

Please provide details of procedure(s). _____

_____

_____

_____

_____

3. Investigations/Laboratory report

	YES	NO
i. Was a biopsy of the tumor performed?	☐	☐
ii. Was the HIV test performed?	☐	☐

If 'YES', please give result. _____ (MM/DD/YY)

_____

iii. Please enclose copies of all reports that are available.

- ☐ HIV test
- ☐ Surgical reports
- ☐ X-rays
- ☐ Tumor markers
- ☐ Any other imaging studies
- ☐ Any relevant laboratory evidence
- ☐ Any relevant hospital reports
- ☐ Cytology reports
- ☐ Pathological reports
- ☐ CT scans / MRI

4. Please state if the insured has suffered/been treated for any other illness (es)/complaints other than the Critical Illness.

_____

_____

_____

5. If there any further information which in your opinion will assist us in assessing this claim, please furnish such information below.

_____

_____

_____

Details of "YES" answers.
(Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities)

To be completed by Attending Physician

I hereby certify that I have personally examined and treated the insured in connection with the above disability and that the facts are in my opinion as given above.

Name of Doctor _____ Signature _____

Qualification _____ Specialty _____ Thailand's Medical registration _____

Name of Hospital/Official Stamp _____ Telephone No. _____ Date _____