ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง

Part III Details of Insured's Illness

ECIR-19	**CEREBRAL ANEURYSM REQUIRING BRAIN SURGERY**

1. i. When was the sign/symptom first appeared? _____ (MM/DD/YY)

ii. When was the date of diagnosis of cerebral aneurysm? _____ (MM/DD/YY)

2. What is the nature of treatment?

i. Was craniotomy performed? YES ☐ NO ☐

Date of operation _____ (MM/DD/YY)

If 'YES', state the surgical procedure used to correct the Cerebral Aneurysm?

_____

_____

_____

_____

_____

ii. What other forms of treatment were render?

_____

_____

_____

3. Investigations/Laboratory report

i. Was the HIV test performed? YES ☐ NO ☐

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

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

- ☐ HIV test
- ☐ Surgical reports
- ☐ Cerebral angiography
- ☐ X-rays
- ☐ CT scans
- ☐ MRI , MRA
- ☐ Any other imaging studies
- ☐ Any relevant laboratory evidence
- ☐ Any relevant hospital reports

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 _____