ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง
Part III Details of Insured's Illness

ECIR-32	BRACHIAL PLEXUS INJURY

1. Please describe the extent of the Brachial Plexus Injury.

i. Date of onset ____________ (MM/DD/YY)

ii. **What was the cause of Brachial Plexus Injury?**

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	YES	NO
iii. Is there evidence of complete and permanent loss of use and sensory functions of an upper extremity caused by avulsion of 2 or more nerve roots of brachial plexus?	☐	☐
iv. Is there the complete injury of 2 or more nerve roots confirmed by an electrodiagnostic study?	☐	☐

If 'YES', please describe finding. ______________________________

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2. What is the current condition of the insured and what is the prognosis?

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3. Investigations/Laboratory report

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

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

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

- ☐ HIV test
- ☐ Neurological reports
- ☐ Electrodiagnostic study (NCS / EMG)
- ☐ Myelography
- ☐ MRI
- ☐ Any other imaging studies
- ☐ 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.

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

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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 ____________