ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง

Part III Details of Insured's Illness

ECIR-43	LOSS OF INDEPENDENT LIVING

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

1. What is the age of onset of permanent inability to perform the activities of Daily Living ____________

2. Please describe the extent of the disease.

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

ii. What is the cause of permanent inability to perform the activities of Daily Living with or without the use of mechanical equipment, special devices or other aids and adaptations for disable persons?

- ☐ Illness ____________
- ☐ Injury ____________
- ☐ Degenerative ____________

iii. What is the diagnosis? ____________

____

iv. Date of last treatment ____________ (MM/DD/YY)

Condition of the insured on that date ____________

____

3. Is insured able to perform without physical assistance the following?

	YES	NO
i. Ability to wash and bath by herself	☐	☐
ii. Ability to dress/undress by herself	☐	☐
iii. Ability to attend to her own toilet needs	☐	☐
iv. Ability to feed by herself	☐	☐
v. Ability to move in or out of a bed or a chair by herself	☐	☐
vi. Ability to move from room to room by herself	☐	☐

4. 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
- ☐ Radiological procedures
- ☐ Any other imaging studies
- ☐ Any relevant laboratory evidence
- ☐ Any relevant hospital reports
- ☐ Neurological reports
- ☐ CT scans

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

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6. 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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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 ____________