ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง
Part III Details of Insured's Illness

ECIR-7 CIR-8	PARALYSIS

1. Please describe the extent of the disease.

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

ii. The area of involvement. _____

_____

_____

iii. Is the loss of use of the involved limbs considered complete and permanent? If 'YES', please provide basis for prognosis. YES ☐ NO ☐

_____

2. What was the cause of the paralysis?

_____

_____

_____

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
- ☐ Neurological reports
- ☐ Surgical reports
- ☐ X-rays
- ☐ CT scans
- ☐ MRI
- ☐ NCS / EMG
- ☐ 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 _____