ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง

Part III Details of Insured's Illness

ECIR-15	**BLINDNESS**

1. Please describe the extent of the blindness.

i. When was the date of onset _____ (MM/DD/YY)

ii. What are the visual acuity of both eyes at present? Left eye _____ Right eye _____

iii. What are the visual field of both eyes at present? Left eye _____ Right eye _____

iv. What forms of treatment were rendered?

_____

_____

v. Was the loss of sight Left eye ☐ Permanent ☐ Temporary

Right eye ☐ Permanent ☐ Temporary

vi. Will further surgery improve his/her sight? YES ☐ NO ☐

If 'YES', what kind of surgery will be necessary.

_____

_____

2. What was the cause of the blindness?

_____

_____

_____

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
- ☐ Opthalmologist report of visual examination
- ☐ CT scans
- ☐ MRI
- ☐ 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 _____