ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง

Part III Details of Insured's Illness

ECIR-18 CARDIOMYOPATHY

1. Please describe the extent of the disease.

i. Date of first diagnosis _____ (MM/DD/YY)

	YES	NO
ii. Is there persistent impairment of left ventricular function (diastolic or systolic), despite optimal treatment.	☐	☐
iii. Has the condition in (ii) been present for at least 6 months?	☐	☐
If 'YES', please definite date of last treatment. _____ (MM/DD/YY)		
iv. Was echocardiogram performed?	☐	☐
v. Was coronary arteriography performed?	☐	☐

vi. What was the patient functional class? (according to New York Heart Association of cardiac impairment) _____

2. What was the cause of the cardiomyopathy?

_____

_____

3. History of alcohol intake.

	YES	NO
i. Is patient habitually drunk or suffered physically from the effects of alcohol? If 'YES', please state type of alcohol consumed and amount.	☐	☐
ii. Have patient ever been advised to reduce or discontinue his alcohol intake? If 'YES', please provide detail.	☐	☐
iii. Have patient ever received medical treatment for excessive consumption of alcohol? If 'YES', please provide detail.	☐	☐

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
- ☐ Isotope studies
- ☐ Resting ECGs
- ☐ Exercise stress tests
- ☐ Echocardiograms
- ☐ Coronary angiography
- ☐ Any relevant laboratory evidence
- ☐ Any relevant hospital reports

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

_____

_____

6. 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 _____