### Part III  Details of Insured’s Illness

**FIRST HEART ATTACK**

1. **Please describe the heart attack.**
   - **i. Date of the episode**
     - (MM/DD/YY)
   - **ii. Was there a history of typical ischaemic chest pain?**
     - YES
     - NO
   - **iii. Was there a serial elevation of cardiac enzymes (Cardiac Troponin (T or I), CPK, CPK-MB, LDH) documented?**
     - YES
     - NO
   - **iv. Were there any new changes in the ECG indicative of a myocardial infarction?**
     - YES
     - NO
   - **v. Duration of the acute symptoms,**
   - **vi. Date of return to normal activities and/or the insured’s present limitations,**
     - (MM/DD/YY)

2. **Was there death of a portion of the heart muscle?**
   - YES
   - NO
   - If ‘YES’, please describe.

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
     - Cardiac Enzymes assays
     - Isotope studies
     - Resting ECGs
     - Exercise stress tests
     - Echocardiograms
     - Coronary angiography
     - Any relevant hospital reports

4. **Please state if the insured has previously suffered/been treated for any of the following conditions**
   - Smoking
     - YES
     - duration ________ yrs
     - No
     - Dyslipidemia
     - YES
     - duration ________ yrs
     - No
   - DM
     - YES
     - duration ________ yrs
     - No
     - IHD
     - YES
     - duration ________ yrs
     - No
   - HT
     - YES
     - duration ________ yrs
     - No
     - CVD
     - YES
     - duration ________ yrs
     - No
   - Other illness :

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

---

**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**