**ECIR-23 END STAGE LUNG DISEASE**

1. Please provide full and exact details of the diagnosis and etiology:

   i. Was the insured chronic lung disease?  
      
      | YES | NO |
      |-----|----|
      |     |    |

      If ‘YES’, diagnosis date (MM/DD/YY) and the cause ____________________________________________

   ii. What was the volume of the arterial blood oxygen partial pressure (PaO2) whilst breathing room air Mmol/L ____________________________________________

   iii. Did the Insured require permanent oxygen therapy?  
      
      | YES | NO |
      |-----|----|
      |     |    |

      If ‘YES’, start date (MM/DD/YY) ____________________________________________

2. What was the cause of chronic lung disease?

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
      - Arterial blood gas (room air)
      - Pulmonary function test
      - Resting ECGs
      - Echocardiograms
      - X-rays
      - CT scans / Lung scan
      - MRI
      - 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.

**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 ____________________________