ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง

Part III Details of Insured's Illness

ECIR-25 LIVER FAILURE

1. i. What was the date of diagnosis of Liver Failure/Liver cirrhosis? _____ (MM/DD/YY)

ii. The diagnosis was made from _____

2. Please provide details	**YES**	**NO**
i. Is there permanent jaundice?	☐	☐
ii. Is there ascites?	☐	☐
iii. Is there hepatic encephalopathy or hepatorenal syndrome	☐	☐

3. What is the underlying cause?

_____

4. What is the current condition of the insured and what is the prognosis?

_____

_____

5. History of alcohol intake.

	YES	NO
i. Is patient habitually drunk or suffered physically from the effects of alcohol? If 'YES', please state type , amount and duration of alcohol consumed.	☐	☐
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.	☐	☐

6. 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
- ☐ Renal function test
- ☐ Ultrasound
- ☐ MRI
- ☐ Any other imaging studies
- ☐ Any relevant laboratory evidence
- ☐ Any relevant hospital reports
- ☐ Liver function test / Coagulogram
- ☐ EEG
- ☐ CT scans

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

_____

_____

8. 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 _____