ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง

Part III Details of Insured's Illness

ECIR-28	MOTOR NEURONE DISEASE

1. Please describe the extent of the disease.

i. When was the sign/symptom first appeared? _____ (MM/DD/YY)

ii. What was the date of diagnosis of motor neurone disease ? _____ (MM/DD/YY)

Please specify type : ALS , PLS , PMA etc…… _____

iii. What was the cause of the above diagnosis? _____

_____

	YES	NO
iv. Are there definitive evidence of appropriate and relevant neurological signs Supporting the diagnosis? If 'YES', please elaborate.	☐	☐

_____

_____

2. Is insured able to perform without physical assistance the following?

	YES	NO
i. Ability to wash and bath by herself	☐	☐
ii. Ability to dress/undress by herself	☐	☐
iii. Ability to attend to her own toilet needs	☐	☐
iv. Ability to feed by herself	☐	☐
v. Ability to move in or out of a bed or a chair by herself	☐	☐
vi. Ability to move from room to room by herself	☐	☐

3. 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
- ☐ Neurological reports
- ☐ Electrodiagnostic study
- ☐ Cerebrospinal fluid studies
- ☐ CT scans / 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.

_____

_____

_____

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 _____