ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง

Part III Details of Insured's Illness

ECIR-2 CIR-2	STROKE

1. Please describe the initial episode.

i. Date of the episode _____ (MM/DD/YY)

ii. Nature of the episode (Hemorrhage,Thrombosis or Embolism) _____

iii. Location and extent of lesion _____

iv. What was the cause of stroke? _____

v. Duration of the acute symptoms _____

vi. Date of return to normal activities _____ (MM/DD/YY)

vii. Did the patient present limitation , physical and mental ? YES ☐ NO ☐

2. Please comment on any neurological sequela, which lasted more than 24 hours.

_____

_____

Are these sequela permanent? _____

_____

3. What is the underlying cause?

_____

4. 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
☐ Neurological reports
☐ CT scans
☐ MRI
☐ Any other imaging studies
☐ Any relevant laboratory evidence
☐ Any relevant hospital reports

5. 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 ☐	Heart disease	YES ☐	duration _____ yrs	No ☐
HT	YES ☐	duration _____ yrs	No ☐	CVD	YES ☐	duration _____ yrs	No ☐

Other 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 _____