ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง

Part III Details of Insured's Illness

ECIR-30	SYSTEMIC LUPUS ERYTHEMATOSUS

Details of "YES" answers.
(Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities)

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 SLE ____________ (MM/DD/YY)

	YES	NO
iii. The diagnostic criteria of the American College of Rhumatology are met.	☐	☐

If'YES' , please elaborate

1. ____________
2. ____________
3. ____________
4. ____________

	YES	NO
iv. Was the insured suffered from Cardiac, Central Nervous System or Renal impairment?	☐	☐

If 'YES', please describe finding. ____________

2. What is the nature of treatment?

____

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

____

4. 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
- ☐ Echocardiogram
- ☐ 24 hour urine
- ☐ Renal Function test
- ☐ Any relevant laboratory evidence
- ☐ EKG
- ☐ ANA profile / anti ds-DNA
- ☐ Neurological report
- ☐ Any other imaging studies
- ☐ Any relevant hospital reports

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

____

6. 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 ____________