ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง

Part III Details of Insured's Illness

ECIR-33	SEVERE RHEUMATOID ARTHRITIS

1. Please describe the extent of the disease.

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

ii. What is the date of diagnosis of rheumatoid arthritis ? _____ (MM/DD/YY)

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

If 'YES' , please elaborate

1. _____
2. _____
3. _____

	YES	NO
iv. Widespread joint destruction and major deformity of three or more of the following joint areas: hands, wrist, elbows, knees, hips, ankle cervical spine or feet confirmed by both clinical and radiological evidence.	☐	☐

If 'YES', please describe finding. _____

v. Joint destruction and region deformity are

1. _____ Date of onset _____
2. _____ Date of onset _____
3. _____ Date of onset _____

vi. Date of last treatment ? _____ (MM/DD/YY)

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 ☐ Serum Rheumatoid Factor
☐ Radiological studies ☐ Any relevant 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 _____