ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง

Part III Details of Insured's Illness

ECIR-35	CHRONIC RELAPSING PANCREATITIS

1. Please describe the extent of the disease.

	YES	NO
i. Is there multiple episodes of proven acute pancreatitis over a period on not less than 2 years?	☐	☐
If 'YES', please give date of episode. _____		
ii. Is there widespread calcification within the pancreas?	☐	☐
iii. Is there chronic continous pancreatic dysfunction manifesting in either intestinal malabsorption (steatorrhea) or diabetes mellitus?	☐	☐

If 'YES' , please provide detail. _____

iv. What is the cause of chronic relapsing pancreatitis? _____

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

_____

_____

3. History of alcohol intake.

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

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
- ☐ Fasting Blood Sugar & HBA1C
- ☐ Ultrasound / CT abdomen
- ☐ Any relevant laboratory evidence
- ☐ Stool or urine examination
- ☐ Pancreatic function test
- ☐ Any relevant 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.

_____

_____

_____

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 _____