ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง

Part III Details of Insured's Illness

ECIR-36	SEVERE ULCERATIVE COLITIS OR CRONH'S DISEASE

1. Please describe the extent of the disease.

	YES	NO
i. Has total colectomy been performed ?	☐	☐
ii. Have multiple partial bowel resections been performed during different periods of hospitalization?	☐	☐
iii. Is there associate with assending sclerosing cholangitis?	☐	☐
iv. Is there autoimmune chronic active hepatitis, with cirrhosis?	☐	☐
v. Was there carcinoma insitu of colon?	☐	☐

i. Has total colectomy been performed ?
If 'YES', please give date of surgery. ______________________

ii. Have multiple partial bowel resections been performed during different periods of hospitalization?
If 'YES', please give date and details of surgery. ______________________

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iii. Is there associate with assending sclerosing cholangitis?

iv. Is there autoimmune chronic active hepatitis, with cirrhosis?
If 'YES', please give date of diagnosis and pathological reports

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v. Was there carcinoma insitu of colon?
If 'YES', please give date of diagnosis and pathological reports ______________________

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

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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
- ☐ Operative reports
- ☐ Pathological reports
- ☐ Liver function test
- ☐ Ultrasound
- ☐ Any other imaging studies
- ☐ Any relevant laboratory evidence
- ☐ Any relevant hospital reports
- ☐ Stool examination
- ☐ Sigmoidoscope / Colonoscope
- ☐ ERCP
- ☐ Barium enema
- ☐ CT scans

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

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5. If there any further information which in your opinion will assist us in assessing this claim, please furnish such information below.

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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 ______________________