

ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง

Part III Details of Insured's Illness

ECIR-44	TOTAL AND PERMANENT DISABILITY																					
<p>1. What is the age of onset of Total and Permanent Disability? _____</p> <p>2. Please describe the extent of the disease.</p> <p>i. Date of onset _____ (MM/DD/YY)</p> <p>ii. What is the cause of totally and irreversibly disabled incapable of being employed or engaged in any work or any occupation whatsoever for remuneration or profit? <input type="checkbox"/> Illness _____ <input type="checkbox"/> Injury _____</p> <p>iii. What is the diagnosis? _____ _____</p> <p>iv. Date of last treatment _____ (MM/DD/YY) Condition of the insured on that date _____ _____</p>	<p>Details of "YES" answers. (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities)</p>																					
<p>3. Is insured able to perform without physical assistance the following?</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">YES</th> <th style="width: 10%; text-align: center;">NO</th> </tr> </thead> <tbody> <tr> <td>i. Ability to wash and bath by herself</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>ii. Ability to dress/undress by herself</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>iii. Ability to attend to her own toilet needs</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>iv. Ability to feed by herself</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>v. Ability to move in or out of a bed or a chair by herself</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>vi. Ability to move from room to room by herself</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>		YES	NO	i. Ability to wash and bath by herself	<input type="checkbox"/>	<input type="checkbox"/>	ii. Ability to dress/undress by herself	<input type="checkbox"/>	<input type="checkbox"/>	iii. Ability to attend to her own toilet needs	<input type="checkbox"/>	<input type="checkbox"/>	iv. Ability to feed by herself	<input type="checkbox"/>	<input type="checkbox"/>	v. Ability to move in or out of a bed or a chair by herself	<input type="checkbox"/>	<input type="checkbox"/>	vi. Ability to move from room to room by herself	<input type="checkbox"/>	<input type="checkbox"/>	
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<p>4. Investigations/Laboratory report</p> <p>i. Was the HIV test performed? YES <input type="checkbox"/> NO <input type="checkbox"/> If 'YES', please give result. _____ (MM/DD/YY)</p> <p>ii. Please enclose copies of all reports that are available.</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> HIV test</td> <td><input type="checkbox"/> Neurological reports</td> </tr> <tr> <td><input type="checkbox"/> Radiological procedures</td> <td><input type="checkbox"/> CT scans</td> </tr> <tr> <td><input type="checkbox"/> Any other imaging studies</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Any relevant laboratory evidence</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Any relevant hospital reports</td> <td></td> </tr> </table>	<input type="checkbox"/> HIV test	<input type="checkbox"/> Neurological reports	<input type="checkbox"/> Radiological procedures	<input type="checkbox"/> CT scans	<input type="checkbox"/> Any other imaging studies		<input type="checkbox"/> Any relevant laboratory evidence		<input type="checkbox"/> Any relevant hospital reports													
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<p>5. Please state if the insured has suffered/been treated for any other illness (es)/complaints other than the Critical Illness.</p> <p>_____</p> <p>_____</p> <p>_____</p>																						
<p>6. If there any further information which in your opinion will assist us in assessing this claim, please furnish such information below.</p> <p>_____</p> <p>_____</p> <p>_____</p>																						

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 _____
Name of Hospital/Official Stamp _____	Thailand's Medical registration _____
Telephone No. _____	Date _____