ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง

Part III Details of Insured's Illness

ECIR-6 CIR-7	MULTIPLE SCLEROSIS

1. Please describe the extent of the disease.

i. When was the first attack ? _____ (MM/DD/YY) Sign / Symptom _____

ii. When was the last attack ? _____ (MM/DD/YY) Sign / Symptom _____

iii. Which CNS areas are involved? (please specified) _____

iv. Are there any permanent neurological deficit? YES ☐ NO ☐
If 'YES', please specified.

_____

v. Diagnostic categories for multiple sclerosis in this patient. ☐ Definite ☐ Probable ☐ At risk

2. i. Date of return to normal activities _____ (MM/DD/YY)

ii. Did the patient present limitation , physical and mental ? YES ☐ NO ☐

3. Investigations/Laboratory report

i. Was the HIV test performed? YES ☐ NO ☐
If 'YES', please give result. _____ (MM/DD/YY)

_____

ii. Please enclose copies of all reports that are available.

- ☐ HIV test
- ☐ CSF studies
- ☐ VEP / BAEP
- ☐ CT scan
- ☐ Any other imaging studies
- ☐ Any relevant hospital reports
- ☐ Neurological reports
- ☐ Electromyogram studies
- ☐ X-rays
- ☐ MRI
- ☐ Any relevant laboratory evidence

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 _____