ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง

Part III Details of Insured's Illness

ECIR-8 CIR-9	**POLIOMYELITIS**

1. Please describe the extent of the disease.

i. Date of onset _____ (MM/DD/YY)

ii. Was there any resulting paralysis? YES ☐ NO ☐

If 'YES', where is the area of involvement.

_____

_____

_____

iii. The condition as above has been present for at least 3 months. ☐ ☐

If 'YES', please definite date of last treatment. _____ (MM/DD/YY)

iv. Is Poliovirus identified as the cause ? YES ☐ NO ☐

If 'YES', by

☐ Viral culture from _____ ☐ PCR from _____

2. What is the current prognosis of the insured?

_____

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
- ☐ Serologic marker of Polio Virus / CSF studies
- ☐ Viral culture
- ☐ PCR of entero/Poliovirus
- ☐ Neurological reports
- ☐ X-rays
- ☐ CT scans
- ☐ Any other 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 _____