ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง

Part III Details of Insured's Illness

ECIR-9 / CIR-10 **MUSCULAR DYSTROPHY**

1. Please describe the extent of the disease.

i. Age of onset : _____ years old

ii. Is there evidence of sensory disturbance, abnormal cerebrospinal fluid, or diminished tendon reflex? YES ☐ NO ☐

If 'YES', please describe finding. _____

iii. What are the muscle involved? _____

iv. What is the specific type of muscular dystrophy? _____

2. Is there evidence of family history of muscular dystrophy? YES ☐ NO ☐

If 'YES' , please describe _____

3. Is the diagnosis confirmed by an electromyogram? YES ☐ NO ☐

by muscle biopsy? ☐ ☐

4. Is insured able to perform without physical assistance the following? YES NO

i. Ability to wash and bath by herself ☐ ☐

ii. Ability to dress/undress by herself ☐ ☐

iii. Ability to attend to her own toilet needs ☐ ☐

iv. Ability to feed by herself ☐ ☐

v. Ability to move in or out of a bed or a chair by herself ☐ ☐

vi. Ability to move from room to room by herself ☐ ☐

5. 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 ☐ Neurological reports

☐ Electromyogram ☐ Muscle enzyme

☐ Muscle biopsy ☐ Any relevant laboratory evidence

☐ Any relevant hospital reports

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

_____

_____

_____

7. 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 _____