ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง

Part III Details of Insured's Illness

ECIR-44	**TOTAL AND PERMANENT DISABILITY**

1. What is the age of onset of Total and Permanent Disability? _____

2. Please describe the extent of the disease.

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

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?

☐ Illness _____

☐ Injury _____

iii. What is the diagnosis? _____

_____

_____

iv. Date of last treatment _____ (MM/DD/YY)

Condition of the insured on that date _____

_____

_____

_____

_____

_____

_____

3. ADL Assessment

3a. Prior to Disability: Is insured able to perform without physical assistance the following?

	YES	NO
i. Ability to wash and bath by herself/himself	☐	☐
ii. Ability to dress/undress by herself/himself	☐	☐
iii. Ability to attend to her/his own toilet needs	☐	☐
iv. Ability to feed by herself/himself	☐	☐
v. Ability to move in or out of a bed or a chair by herself/himself	☐	☐
vi. Ability to move from room to room by herself/himself	☐	☐

3b. Post Disability: Is insured able to perform without physical assistance the following?

	YES	NO	If 'No' Please specify. Permanent	Temporary
i. Ability to wash and bath by herself/himself	☐	☐	☐	☐
ii. Ability to dress/undress by herself/himself	☐	☐	☐	☐
iii. Ability to attend to her/his own toilet needs	☐	☐	☐	☐
iv. Ability to feed by herself/himself	☐	☐	☐	☐
v. Ability to move in or out of a bed or a chair by herself/himself	☐	☐	☐	☐
vi. Ability to move from room to room by herself/himself	☐	☐	☐	☐

Date of ADL Assessment: _____ (MM/DD/YY)

Details of "YES" answers.
(Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities)

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4.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
- ☐ CT scans
- ☐ Radiological procedures
- ☐ Any other imaging studies
- ☐ Any relevant laboratory evidences
- ☐ Any relevant hospital reports

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

_____

_____

_____

_____

6. 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: _____