ความเห็นของแพทย์ผู้ตรวจรักษา
CONFIDENTIAL MEDICAL CERTIFICATE

กรุณากรอกข้อความต่างๆให้สมบูรณ์ โดยแพทย์ปริญญาและมีใบประกอบโรคศิลป์ หากมีค่าธรรมเนียมผู้เอาประกันเป็นผู้รับผิดชอบ
Must be completed for all critical illness to be claimed by Doctor at insured's expense

ชื่อผู้ป่วย: นาย / นาง / นางสาว Patient's Name: Mr. / Mrs. / Miss	HN:
เลขที่บัตรประชาชน Identification Number ☐ ☐☐☐☐ ☐☐☐☐☐ ☐☐ ☐ อายุ Age _____ ปี year	AN:
	XN:

ข้อมูลทั่วไป
General Information

	Yes	No
a. Are you the Insured's usual medical physician? If "YES", over what period do your records extend? _____	☐	☐
b. When were you first consulted for this illness? What were the symptoms and at that time how long had they been present? _____	_____ DD/MM/YY	
c. Has the Insured previously suffered from the illness or any related condition? If "YES", please give dates of consultations and the resulting diagnosis. _____	☐	☐
d. On which date was the diagnosis made? _____	_____ DD/MM/YY	
e. Is there anything in the Insured's family history which would have increased the risk of illness? If "YES", please give details of the Insured's family history	☐	☐

Details of Diagnosis

Please provide full and exact details of the diagnosis

Other/Additional Information

Please provide names, addresses and dates of doctors and hospitals, which the Insured has been referred and/or admitted to