Medical certificate

EUROPÄISCHE REISEVERSICHERUNG
WIR SIND DABEI

Hotel

Please sent this certificate immediately to Assiconsult (Fax. +39/0471/069911)

To be completed by the doctor who treated you (by the specialist if specialist treatment was given, or by the hospital if treatment was given in hospital)

Dear Doctor,
We have received notification of claims relating to travel cancellation insurance as a result of the illness/accident suffered by your patient. To enable us to process the claim in accordance with our conditions, we would be grateful if you would answer the following questions in full. Our insured is obliged, under the terms of Art. 7, point 1.7. of the conditions of insurance for hotel industry, to release you from your obligation of confidentiality. Thank you for taking the trouble to answer these questions. Europäische Reiseversicherung AG

Medical certificate

Name of patient: ______________________________ Date of birth: ____________

Address: ____

1. Precise diagnoses (please write legibly):

   Treatment prescribed:

   Was the patient treated as a hospital inpatient as a result of the diagnosis made?

   ☐ No ☐ Yes ☐ Name of hospital: ____________________ from __________ to ____________

   Notification of illness to social insurance

   ☐ No (state reason): ____________________________________

   ☐ Yes (enclose copy of notification) from ____________ to ____________

2. When did the patient become ill / when did the accident occur? Date*: ________________

3. When did the incapacity to travel first become evident? Date*: ________________

* if these dates do not coincide, please state reason:

____

4. Was the patient to be regarded as fit to travel when the insurance was taken out / when the trip was booked (Date: ____________)?
   ☐ No ☐ Yes

5. Is the illness one that has existed for some time? ☐ No ☐ Yes since: ____________
   Has any serious and unexpected deterioration occurred? ☐ No ☐ Yes
   Has the patient received hospital treatment in the last 12 months in consequence of the diagnosis made?

   ☐ No ☐ Yes ☐ Name of hospital: ____________________ from ____________ to ____________

Space for additional comments:

By my signature given below I confirm that the above named patient was not fit to travel to the destination ____________________ with date of travel commencing on ____________ and that the information I have given is correct and complete. I undertake to provide verbal information on the certified information provided here to the confidential doctors of the insurer. The insurer reserves the right to take legal action in the event of any untrue information being given, in accordance with §146 of the Penal Code.

Date, stamp and signature of doctor