

**MEDICAL ACCIDENT & ILLNESS/DENTAL/ PERMANENT DISABILITY BENEFIT/EMERGENCY MEDICAL EVACUATION,
PRESCRIBED MEDICINE/RECUPERATION AT HOTE**

In event accident, details of accident i.e. how, when, where it took place:

Date: Place:

In event of illness, state nature and diagnosis, and advise when & where symptoms first occurred:

Date: Place:

Name & Address of consulting physician:

Have you ever been treated for this illness before: Yes No

If yes, provide name & address of physician:

Provide name & address of your family physician:

Provide name of any prescription medicine you are presently taking :.....

Indicate other health insurance coverage, including name, address, policy number & certificate number of insurer:

DETAILS OF MEDICAL EXPENSES

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Details of treatment	In/ Out Patient Date	Charges (Currency)	Paid/ Outstanding

Attending Doctor's Report

Patient's Name: Age: Sex: M / F

Address:

Date contacted: Time:

For Accidental Injury/Permanent Disability

Nature of Injury:

X-Ray Taken: Yes No Date taken:

Diagnosis and Treatment Given:

Describe any other disease or infirmity affecting present condition:

For Sickness/Emergency Medical Evacuation/Recuperation At Hotel/Prescription Medicine Replacement /Dental Examination

Nature of Illness:

Diagnosis and Treatment Given:

When did patient's symptoms first appear:
 Describe any other disease or infirmity affecting present condition:

Is condition due to Pregnancy: Yes No Is illness due to any pre-existing condition: Yes No

If yes, please explain:
 Signature: _____
 Attending Doctor's Signature

ACCIDENTAL DEATH/REPATRIATION OF REMAINS

In event accident, details of accident i.e. how, when, where it took place:

In event of illness, state nature and diagnosis, and advise when & where symptoms first occurred:

Please, provide eye witnesses names/mobiles /adresses:
 Please, provide name of any prescription medicine you are currently taking / Doctor name :

when and where the death occurred:
 Who paid ?
 How much was it paid? Type of the payment:

LEGAL FEES/ BAIL BOND ASSURANCE

Describe incident:

State of the incident:

Name of the eye witness :

Eye witness' Phone Numbers.....

Lawsuit filed?: Yes No [Please forward a copy of the suit (police report, public prosecutor report, eye witness report,etc.)]

Have you contacted an attorney ? If so, provide name, full adress, phone numbers

AUTHORIZATION

I hereby, automatically authorize through the policy, this declaration and the pre-authorization, that any hospital, physician, or other person who has attended or examined me, to furnish the insurance company, or its authorized representative, any and all information regarding any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records pertinent to this claim, a copy of this authorization shall be deemed as effective and as valid as the original.

Date:..../...../.....

Name, surname

Signature