

Medical questionnaire

Policy no. or first 8 digits of credit card no. _____

Claim no. _____

Medical questionnaire (to be completed by the doctor)

(to be forwarded to Europäische Reiseversicherung AG)

To confirm that the patient is unable to travel due to illness/accident/pregnancy, please fill in the following form in full and accurately.

Attending doctor	
_____	_____
Title, First- and Last name	Street, House no., Door no.
_____	_____
Phone	Zipcode, City, Country
Patient	
_____	_____
Title, First- and Last name	Street, House no., Door no.
_____	_____
Date of birth	Zipcode, City, Country

Travel destination: _____

Departure date: _____

1. Precise diagnosis (please write legibly):

2. Course of therapy:

3. When did the patient become ill / When did the accident occur / When was the diagnosis made? Date: _____
(in case of pregnancy: when was pregnancy detected)

Hospital stay: No Yes – from _____ to _____

Reported sick to your national health service provider: No Yes – from _____ to _____

Medical questionnaire

4. Is your patient unable to travel on this trip for medical reasons?

No Yes – When did patient's inability to travel become apparent? Date: _____

In the event that a non-travelling family member (such as life partner, children, parents, siblings) was affected:

When did it become apparent that the presence of the insured was urgently needed? Date _____

5. Is this because of a pre-existing illness or the consequence of an accident? No Yes

6. Only to be completed in the case of existing illness or consequence of an accident:

Has the existing illness/consequence of an accident become acute unexpectedly? No Yes

When did the illness/consequences of the accident first occur? Date: _____

In the last 9 months / 12 months BEFORE THE POLICY WAS TAKEN OUT / THE TRAVEL BOOKING WAS MADE was the patient receiving in-patient treatment in connection with the diagnosis stated above (excluding check-up examinations)?

No Yes

In the last 6 months BEFORE THE POLICY WAS TAKEN OUT / THE TRAVEL BOOKING WAS MADE was the patient receiving outpatient treatment in connection with the diagnosis stated above (excluding check-up examinations)?

No Yes

Space for additional comments:

By signing, I confirm that the above information I have provided is accurate and complete. I undertake to provide the insurer's medical officers with information verbally about the relevant medical information. The insurer reserves the right to take legal action if information is untrue, in accordance with Section 146 of the Austrian Criminal Code.

Which doctor is in the best position to provide information about the circumstances of this illness?

Name, address and phone of the doctor

Date, office stamp and signature of the attending doctor