

This form needs to be filled in at the request of the policyholder by the doctor in attendance!

Touroperator _____ PO/file number _____
 Travel organisation _____ File number Protections _____

Policyholder Name & first name _____
Patient Name & first name _____
 Date of birth | |
 Relation to the policyholder _____

1. Detailed description of your diagnosis _____

2. At what time did the patient first apply for treatment | |
3. Kind of treatment _____
4. Kind of medication _____
5. Duration and frequency of treatment and medication _____
6. Date of the last consultation | |
 Reason _____
7. At which point in time was the planned trip advised against? | |
 Why? _____
8. Must the activities be interrupted? NO YES, from | | until | |
9. Is leaving the house permitted? YES NO, from | | until | |
10. Did the patient receive any earlier treatment for this complaint? NO YES, from | | until | |
11. Does this concern a renewed attack? NO YES, from | | until | |
12. Was (is) it necessary to hospitalize the patient? NO YES, from | | until | |
13. Antecedents?
 Medical _____
 Surgical _____
14. In case of pregnancy: what is the normal delivery date? | |
15. Other clarifications _____

Date | |

Stamp

Signature

Please send this questionnaire under closed and confidential cover to PROTECTIONS,
 Attn: Physician Advisor, Sleutelplasstraat 6, 1700 Dilbeek, Belgium.
 T +32 (0)2 463 5000 | F +32 (0)2 463 55 55 | E claims@protections.be

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