Group insurance (Health Care)

AG INSURANCE

Medical certificate

ℯ-volulife

GROUP N° ____________________

This document has to be filled out by the attending physician
It has not to be filled out for a confinement.

In any case **1** + **2** in case of **Sickness** / **3** in case of **Accident** + **4** if the contract covers **Disability**

Confidential

This certificate serves to inform the medical adviser of AG Insurance about the nature of the treatment given to the patient and about the length and the degree of the disability, if any.

1 Insured's identity and hospitalization data

Name and first names of the patient (in capital letters) ____________________

Date of birth ____________________

Diagnosis and (or) symptoms of the present ailment ____________________

Date on which you started treating the patient for this accident or disorder ? ____________________

If hospitalization is required, in which establishment does it occur ? (Name and address) ____________________

Beginning of the stay in hospital ____________________ Probable length of the stay ____________________

Has the patient been operated on or will he be operated on ? **Yes** ☐ **No** ☐

Nature of the operation (medical code if any) ____________________

Date (or probable date) ____________________

Is the patient allowed to go out ? **Yes** ☐ **No** ☐

2 In case of Sickness

When did the first outward signs appear ? ____________________

Has the patient previously suffered from any infirmity or sickness which could have predisposed to the present sickness ? **Yes** ☐ **No** ☐

Which one ? ____________________ Since when ? ____________________

Has the patient got treatment from other physicians than yourself ? – for the predisposing disorder ? **Yes** ☐ **No** ☐
– for the present sickness ? **Yes** ☐ **No** ☐

Name and address ____________________

3 In case of Accident

The accident took place on ____________________ at ________ a.m./p/m.

Please give a detailed description of the injury (nature, location, extent, etc...) ____________________

Does the injury affect the neighbouring organs ? **Yes** ☐ **No** ☐ – If **yes**, which one ? ____________________

Has the patient suffered from any infirmity or disorder whatever before the accident ? **Yes** ☐ **No** ☐ – If **yes**, which one ? ____________________

– Does it have any influence on the development of the injury ? **Yes** ☐ **No** ☐ – If **yes**, which one ? ____________________

4 If the contract covers Disability

Commencement of work incapacity ? (exact date) ____________________

Is the present disability total ? **Yes** ☐ **No** ☐ – Presumable duration ______ (as from the date stated above)

If Not, what is its degree? ________ % – Presumable duration ______ (as from the date stated above)

What is your opinion concerning the further development of the disability? ____________________

Date and signature of the physician,

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