Medical certificate

Group insurance (Health Care) - e-volulife

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.

Ask your attending physician to fill out Part Two of this document.

For the birth of a baby, you only need to fill out Part One.

Please return to: AG,
Health Care Medical Dept.– 1JQ5B, Bd. E. Jacqmain 53, 1000 Brussels

CONFIDENTIAL

1. To be filled out for all types of cases

Group number: ..... and/or other reference (for example your card number): .....

Insured's identity: Name: ..... First name: .....

Date of birth: ..... / ..... /.....

To fill out for the birth of a child

Start of postnatal maternity leave: ..... / ..... /.....

Exact date of delivery: ..... / ..... /.....

End of postnatal maternity leave: ..... / ..... /.....

2. To be filled out by the attending physician

In case of Sickness

Diagnosis and (or) symptoms of the present ailment: .....

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

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? ☐ No ☐ Yes

Which one? ..... Since when? ..... / ..... /.....

Has the patient got treatment from other physicians than yourself?

- for the predisposing disorder? ☐ No ☐ Yes

  If Yes, Name and address: .....

  .....

- for the present sickness? ☐ No ☐ Yes

  If Yes, Name and address: .....

  .....

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? ☐ No ☐ Yes

Nature of the operation (medical code if any): .....

Date (or probable date): ..... / ..... /.....

In case of Accident

The accident took place on: ..... / ..... /..... at ..... : ..... ☐ AM ☐ PM

Aard van het ongeval: ☐ Privé ☐ Verkeer ☐ Sport ☐ Werk ☐ Andere: .....

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

.....

.....

.....

Does the injury affect the neighbouring organs? ☐ No ☐ Yes

If yes, which one? .....

Has the patient suffered from any infirmity or disorder whatever before the accident? ☐ No ☐ Yes

If yes, which one? .....

Does it have any influence on the development of the injury? ☐ No ☐ Yes

If yes, which one? .....

Commencement of work incapacity:

..... / ..... /..... (exact date) Return-to-work date (if applicable) van werkhervatting: ..... / ..... /.....

IIs the present disability total? ☐ No ☐ Yes, 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?

.....

.....

.....

.....

.....

Processing of special categories of personal data

- I, undersigned, explicitly agree to the processing of my health data by AG and my authorized representatives for the purpose of describing the risk and/or handling the claim, including the establishment of statistics.
- I, undersigned, explicitly agree to the processing of my personal data relating to criminal convictions and offences by AG and my authorized representatives for the purpose of handling the claim.

AG is controller for the processing of these data and undertakes to comply with its obligations under the applicable privacy legislation.

I have been informed about my right to withdraw my consent for the processing of my health data at any time. I acknowledge that in this case AG will be unable to perform the contractual relationship.

Drawn up in ..... on ..... / ..... /.....

Date and signature of the insured:

Date and signature of the physician: