Medical certificate

CONFIDENTIAL

Group Insurance (Health Care)

This certificate wants to inform the medical advisor of AG about the nature of the treatment given to the patient and the duration and degree of the incapacity for work.

This document should be filled in by the treating physician.

In case of childbirth, you should only fill in the first part.

Please send this document to::
AG, To the attention of the medical advisor
Medical Service Health Care – 1JQ5B
Bd E. Jacqmain 53, 1000 Brussels

1. To be filled in by the insured in all cases

Group no: ..... and/or contract no. or reference if known: .....

Details of the insured:

Last name: ..... First name: ..... Date of birth: ..... / ..... /.....

To be filled in, in case of childbirth:

Start date of maternity leave: ..... / ..... /.....

Exact date of childbirth: ..... / ..... /.....

End date of maternity leave: ..... / ..... /.....

2. To be filled in by the doctor

To be filled in, in case of sickness

Diagnosis and/or symptoms of the disorder: .....

Since when have you been treating this patient for this disorder or accident? ..... / ..... /.....

When did the first symptoms appear? ..... / ..... /.....

Has the patient been treated by another physician?

- for a pre-existing disorder? ☐ No ☐ Yes

  If yes, name and address: .....

  .....

- for a current sickness? ☐ No ☐ Yes

  If yes, name and address: .....

  .....

Is or was the patient hospitalised? If so, where? (name and address of hospital):

.....

.....

Start date of hospitalisation: ..... / ..... /..... Expected duration: .....

Has the patient undergone or will the patient have to undergo surgery? ☐ No ☐ Yes

If yes, what is the nature of the intervention (provide medical code if known):

.....

.....

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

To be filled in, in case of accident

Date of the accident: ..... / ..... /..... at ..... : ..... am/pm

Nature of accident: ☐ Private ☐ Work ☐ Road ☐ Sport ☐ Other: .....

Please provide a detailed description of the injury (nature, area, extent, etc. ...):

.....

.....

.....

Start date of incapacity for work:

..... / ..... /..... (exact date) Expected date of return to work: ..... / ..... /.....

Please indicate if incapacity for work is total ☐ No ☐ Yes

expected duration: ..... (from start date of incapacity)

If not, what is the degree of incapacity? ..... %

expected duration: ..... (from start date of incapacity)

In your opinion, what will be the evolution of the incapacity for work?

.....

.....

.....

Done at: ....., on: ..... / ..... /.....

Insured's signature: Physician's signature and stamp:

As a data controller, AG processes your personal data for the purposes mentioned in the general terms and conditions (the pension plan rules for sectoral supplementary pension), and in particular with a view to managing the supplementary benefits taken out by your employer or sector on your behalf (supplementary pension and/or occupational health insurance) and entrusted to AG for management purposes. More information about the processing of your personal data can be found in the general terms and conditions (the pension plan rules for sectoral supplementary pension) and in our Privacy Notice on www.aginsurance.be.

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