

(Please use block letters) Agent number: 1658-0 Helbich GmbH

Information about the insured	
Policy number	<input type="text"/>
Date of departure (dd/mm/yyyy)	<input type="text"/> Date of return (dd/mm/yyyy) <input type="text"/>
Destination	<input type="text"/>
First name(s)	<input type="text"/>
Family name(s)	<input type="text"/>
Date of birth (dd/mm/yyyy)	<input type="text"/> Sex (M/F) <input type="text"/>
Permanent address	<input type="text"/>
Permanent address	<input type="text"/>
Postal Code	City <input type="text"/>
Country	<input type="text"/>
Telephone	Fax <input type="text"/>
Mobile phone	<input type="text"/>
Email	<input type="text"/>

Information given by the physician	
Diagnosis:	
Type and extent of the treatment:	Date (dd/mm/yyyy) <input type="text"/>
Hospitalisation/treatment by a physician in connection with the illness or its consequences or complications within six months prior to departure:	
Current medical treatment. Change in medication within the last six months prior to departure:	
Expected check-ups or treatment? <input type="radio"/> YES <input type="radio"/> NO	Date (dd/mm/yyyy) <input type="text"/>
Type of treatment:	
Other comments:	
Physician's signature and stamp _____ Date _____	
Please note that any physician's fee for obtaining this medical information must be paid by the applicant.	

