

Worldwide Travel Options

Application for cover of pre-existing conditions

(Please use block letters)

Information about the insured

Policy number	_____ - _____	Date of departure	_____	Date of return	_____
Destination	_____				
First name(s)	_____	Date of birth	_____ - _____		
Family name(s)	_____				Sex (M/F) <input type="checkbox"/>
Permanent address	_____				
Permanent address	_____	Postal Code	_____		
City	_____	Telephone	_____		
Country	_____	Fax	_____		
E-mail	_____				

Information given by the physician

Diagnosis: _____

Type and extent of the treatment: _____

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? YES NO

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.