MAPFRE | ASSISTANCE

l'EUROPÉENNE
d'assurances voyages

Ct 7906062 -

MEDICAL QUESTIONNAIRE

In accordance with the terms of your contract, please ask the doctor to complete the following questionnaire and return it to our medical department in a closed envelope.

Patient identification

Last name : ………………………………………….. First name : ………………………………..

Medical information

Your patient's medical history ……………………………………………………………………………………..

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Your patient's usual treatment ……………………………………………………………………………………..

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Concerning the illness responsible for cancellation

Nature of the illness………………………………………………………………………………………………...

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Date of first symptoms or signs...…………………………………………………………………………………

Treatment prescribed………………………………………………………………………………………………

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Date of diagnosis …………………………………………………………………………..............................

Current treatment ..…………………………………………………………………………………………………

Examinations requested ……………………………………………………………………………………...

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ATTENDING PHYSICIAN'S STAMP

Date and signature

MAPFRE ASSISTANCE - L'Européenne d'Assurances Voyages • 31 – 33 rue de la Baume • 75008 PARIS • Tél : +33.1.46.43.64.40 • Fax +33.1.55.69.39.76

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