Claim form for Tropical and infectious diseases

Insurance policy number

Supporting Organization

Name of the supporting organization	Street, number	Postal code, city
Telephone	Fax	Email

Insured person

Name of the insured		Date of birth
Street, number	Postal code, city	
Telephone	Fax	Email

Information on tropical and infectious diseases

Please name the disease?

Date of initial manifestation

Did you undergo inpatient treatment? ☐ No ☐ Yes

Pre-existing conditions

Which diseases or health problems already existed prior to the tropical/infectious disease?

Do you receive pension payments or has your pensions process started? ☐ No ☐ Yes, because of:

Other insurance

Did or do you have other health insurance policies, including group insurance, with other companies? ☐ No ☐ Yes

If yes, please name insurance company and insurance policy number

Important note / Signature

The policyholder and the insured are required to provide true, accurate and complete information on the data requested. The insurance company is released from its obligation to perform if the policyholder or the insured intentionally or with gross negligence provides incomplete or incorrect information or commits fraudulent misrepresentation. In case of intentionally incorrect information, this legal consequence also ensues if it neither affects the assessment nor the scope of benefits incumbent on the insurer. If you act with gross negligence when violating an obligation, we are entitled to reduce our payment proportional to the severity of your fault.

Place, date	Signature of the policyholder
Place, date	Signature of the insured

Waiver of physician-patient privilege

For (insured person)	Insurance policy number

I authorize the insurer to gather information at any time on the following: former and existing diseases, consequences of an accident and ailments; diseases, consequences of an accident and ailments occurring prior to the termination of the contract; applied-for, existing or terminated personal insurance. For this purpose, the insurer is permitted to question doctors, dentists, non-medical practitioners, all kinds of hospital wards, insurance institutions and pension offices. I hereby release them from their physician-patient privilege and authorize them to provide any necessary information to the insurer.

Place, date	Signature of the insured

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