

## 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