

## Release from medical confidentiality obligation

|   |                 |                |                              |    |
|---|-----------------|----------------|------------------------------|----|
| Policy no.  | 553048          | Claim no.      | (filled out through Allianz) |    |
| <b>A. Personal details</b> (please enter all details in block capitals) |                 |                |                              |    |
| Last name/first name:   |                 | Date of birth: |                              |    |
| Street no.:   |                 | Zipcode/Town:  |                              |    |
| Telefon home:   |                 | Telefon work:  |                              |    |
| Destination:  |                 | Type of trip:  |                              |    |
| Booking date:   | Period of trip: | from           |                              | to |

Dear Insured

Please complete this form with your particulars and travel information and sign the following declaration.

### Release from confidentiality obligation

I am aware that, in order to assess its indemnification obligation, Allianz will check information which I have provided to substantiate my claim. For this purpose I release all involved doctors and their assistants, who are named in the documents I submit or involved in the treatment, from their confidentiality obligation, even after my death. However, this release from the confidentiality obligation only applies in respect of a previous treatment in so far as this information is necessary to check the indemnification obligation.

Place, date

Signature (in the case of minors their legal representative)

## Medical report Cancellation Costs Insurance

|   |  |
|---|--|
| 1a Anamnesis with date of the first doctor's consultation   |  |
|   |  |
| 1b Objective results  |  |
|   |  |
| 1c Diagnosis, which lead to the travel disability with date of the diagnosis - position (In case of pregnancy please note additionally the expected due date) |  |
|   |  |
| 1d Since when was the travel disability?  |  |
|   |  |
| 1e Was the patient entirely fit to travel at the time of the booking?   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2a Were medicaments prescribed? Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
| If yes, what kind of?   |  |
|   |  |
| 2b Were there further treatments or follow-ups arranged?  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If yes, please note the date  |  |
|   |  |
| 2c Did a operation take place?  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If yes, date of the operation   | Finalization of operation date                           |
|   |  |
| Was it a own choice surgery?  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2d Other therapies/measures?  |  |
|   |  |
| 3a Was a hospitalization/clinic stay necessary? Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
| If yes, where?  | from to  |
|   |  |
| 3b Was the patient unable to work?  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If yes, from  | to %   |
| If no, note reasons   |  |
|   |  |

|                    |                |
|--------------------|----------------|
|                    | Doctor's stamp |
| Place, date        |                |
| Doctor's signature |                |