CONFIDENTIAL MEDICAL DECLARATION - SECURE PROCESS

To enable our Medical Examiner to make a decision regarding the payment of your hospital charges, please provide the information requested below. The Medical Examiner will communicate the response within the 72 hours following receipt of your request. The Medical Examiner has the right to request all the required information.

TO BE COMPLETED BY THE INSURED

Your employer
(to be completed only if you are insured through your employer)

Name of employer:	Policy number:

Principal insured

Surname and first name:	Client reference number:
Name of your policy:	E-mail: @

TO BE COMPLETED BY THE PRACTITIONER

Name of hospital:		
Address:		
Telephone:	Fax:	
Name of practitioner:		
Address:		
Telephone:	Fax:	

The patient

Surname and first name:	Sex:
Date of birth (DD/MM/YYYY): / /	

Reason for hospitalisation

Please answer the following questions relative to the payment of hospitalisation charges for the above-named patient:

Reason for hospitalisation: ❍ Medical ❍ Surgery ❍ Maternity ❍ Thermal cure ❍ Other:		
❍ **Due to an accident? If so:**	Date (DD/MM/YYYY): / /	Place:
Circumstances:	Detail of injuries:	
❍ **Caesarean section? If so:**	Date (DD/MM/YYYY): / /	Place:
❍ **Due to illness? If so:**	Which illness:	Diagnosis:
Date of first symptoms (DD/MM/YYYY)**:** / /		
Date of first diagnosis (DD/MM/YYYY)**:** / /		
Length of stay in hospital:	**Date of admission** (DD/MM/YYYY)**:** / /	**Date of discharge** (DD/MM/YYYY)**:** / /
Estimated cost of hospitalisation:		
Hospital fees:	**Practitioner's fees:**	

Practitioner's signature and stamp:

Date:

Patient's signature:

Date:

Return this document in an envelope marked "confidential" to:

The Medical Examiner
C/O APRIL International Expat
110, avenue de la République - CS 51108
75127 Paris Cedex 11 - FRANCE
or
by fax: +33 (0)1 73 02 93 70
E-mail: hospitalisation@aprilmobilite.com