CONFIDENTIAL –

MEDICAL INFORMATION

MEDICAL QUESTIONNAIRE

This document needs to be filled in by the patient and his/her doctor and to be uploaded with the proof documents of your claim.

Warning: Any person who, intending to defraud or knowingly facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of fraud and subject to criminal procedures and/or indemnities. The position of Europ Assistance is to investigate and prosecute any and all fraudulent activity identified.

PART TO BE FILLED BY THE INSURED

Family name: ……

First name(s): ……

Relationship with the Insured person: ……

Address:

……

……

Address where the Insured can be visited:

……

……

Europ Assistance SA, Irish Branch ("EA") – located at 4th floor, 4-8 Eden Quay, Dublin 1, D01 N5W8, Ireland, regulated under the French Insurance Code, registered in the Irish Companies Registration Office under number 907089 – acting as data controller, processes any personal and sensitive data that it collects from this medical questionnaire for the purposes of management of your claim. EA complies with Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data ("GDPR"). You may exercise all rights granted by GDPR via postal mail at: To the attention of EA Global Data Protection Officer, Europ Assistance SA, 1 Promenade de la Bonnette, 92230 Gennevilliers, France ; or via email: eaglobaldpo@europ-assistance.com. *Your data may be processed based on legitimate interest for fraud detection, or to comply with legal obligations. We may share your Personal Data with other companies in the Europ Assistance group or with companies in the Generali Group, external organizations such as our auditors, reinsurers or co-insurers, claims handlers, agents, law enforcement bodies and regulatory authorities, fraud prevention agencies and claims databases, distributors that we use from time to time to provide the service covered by your insurance policy and all other entities that carry out any technical, organizational and operational activities supporting the insurance. Your data may be transferred on a territory that is not recognized as ensuring an adequate level of protection by the European Commission, but in compliance with GDPR. You have the right to lodge a complaint with a supervisory authority should you have any concern regarding the processing of your Personal Data: Commission Nationale de l'Informatique et des Libertés, 3 Place de Fontenoy, TSA 80715, 75334 PARIS CEDEX 07, France, Tel: +33 (0)1.53.73.22.22, Fax: +33 (0)1.53.73.22.00. We will retain your Personal Data for as long as is necessary for the purposes set out above, or for as long as is required by law.*

☐ *I expressly acknowledge and agree that Europ Assistance S.A. (**"EA"**) processes the confidential data collected from this medical questionnaire for the purposes described [location of the information]*

Signature

Date

CONFIDENTIAL –

MEDICAL INFORMATION

Part to be filled by the Doctor

Name and address of the Doctor:

.....

.....

Nature of the illness or injury:

☐ Disease without hospitalization

☐ Disease with hospitalization

☐ Pregnancy

☐ Accident without hospitalization

☐ Accident with hospitalization

Hospitalization = hospital admission

In case of accident

Date of the accident: ☐ / ☐ / ☐

Detailed circumstances of the accident and consequences on the health of the Insured:

.....

.....

.....

Did you examine the patient in person? ☐ **Yes** ☐ **No**

In case of sickness = illness

Date of 1st identification of the sickness: ☐ / ☐ / ☐

In case of relapse, date of initial identification of the relapse: / ☐ ☐ ☐

Did you examine the patient in person? ☐ **Yes** ☐ **No**

Precise nature of the sickness:

.....

.....

Date of start of medical treatment: ☐ / ☐ / ☐

Precise nature of the medical treatment:

.....

.....

CONFIDENTIAL –

MEDICAL INFORMATION

Expected Duration of medical treatment:

……

……

Is the sickness preventing the patient from undertaking the trip ? ……

Sick leave dates: from ☐ / ☐ / ☐ **to** ☐ / ☐ / ☐

If not employed dates at which the patient was not allowed to leave home:

from ☐ / ☐ / ☐ **to** ☐ / ☐ / ☐

Is the patient contagious and cannot be visited? ☐ **Yes** ☐ **No**

Preexisting conditions or specific conditions

(please detail here any information related to the conditions of the patient that have an impact on the ability to travel and the date the conditions have been known)

……

……

In case of hospitalization:

Date of start of the hospitalization: ☐ / ☐ / ☐

End date (or expected end date) of the hospitalization: ☐ / ☐ / ☐

Date of diagnosis:

Cause of the hospitalization:

……

……

……

CONFIDENTIAL –

MEDICAL INFORMATION

Signed in: …… **Date of signature:** ☐ / ☐ /

Signature and stamp of the doctor: