

Application for cover of Pre-Existing condition IHI Travel Insurance

(Please use block letters)

Information about the insured

Policy number	_____	Date of departure	____/____/____	Date of return	____/____/____
Destination	_____				
First name(s)	_____	Date of birth	____/____/____		
Family name(s)	_____	Sex (M/F)	<input type="checkbox"/>		
Permanent address	_____				
Permanent address	_____	Postal Code	_____		
City	_____	Telephone	_____		
Country	_____	Fax	_____		
E-mail	_____				

Information given by the physician

Diagnosis: _____

Which treatment has been given and for how long: _____

Hospitalisation/treatment by a physician in connection with the illness or its consequences or complications within 6 months prior to departure: _____

Current medical treatment. Change in medication within the last 6 months prior to departure:

Expected check-ups or treatment? YES NO

Other comments: _____

Physician's signature and stamp: _____ Date: _____

Please note that any physician's fee for obtaining this medical information must be paid by the client.