Aevitae
P.O. Box 2705
6401 DE Heerlen

Application Form for Medical Treatment Abroad

Please complete this form fully in capital letters in blue or black ink.

1 My details (= the policyholder)

Policy number ______ Insurance collective: ______

Initial(s): ______ Infix: ______ Surname: ______

Date of birth: __ __ - __ __ - __ __ __ __ O Male O Female

BSN (Social Security No.): __ __ __ __ __ __ __ __ __

Nationality: O Dutch O Other: ______

Street name: ______ House number: ______ Suffix: ______

Postal code: ______ Town/city: ______

Country: ______ Telefoonnummer: ______

Email addresss: ______ O Yes, I would like to receive information about my health insurance digitally

2 Indication (own declaration)

Medical indication: ______

Therapy to date: ______

Present medication: ______

Reason for treatment abroad: ______

______

Referred for indication*: ______

*(note, include referral, see point 4)

Treatment datee: __ __ - __ __ - __ __ __ __

3 Details of foreign institution

Name of institution: ______

Address of institution: ______

Postal code: ______ Town/city: ______

Phone number: ______ Fax number: ______

Internet address: ______

4 Enclose necessary details for final assessment

Details to be enclosed:

- O Completed application form
- O Medical indication with foreign medical specialist's treatment plan
- O Referral from GP or medical specialist.
- O Quote

Note, without this necessary information we cannot accept your application for processing..

AEV-18522 (A)

5 Additional notes

____

____

6 Signature

Name: ____

Date: __ __ - __ __ - __ __ __ __ Applicant’s signature: ______________________________

You can e-mail your application to mg@aevitae.com or send it by post to:

Aevitae
Attn: Team Medical
P.O. Box 2705
6401 DE Heerlen

You can also download this form from our website. You can find more information about your application there.