POLICY NUMBER OR GROUP OR CONTRACT

NAME AND SURNAME OF THE INSURED PERSON

DATE OF BIRTH
Y Y Y Y M M D D

DECLARATION OF THE TREATING DOCTOR

To be filled in capital letters and given to the patient

1. DIAGNOSIS

1.1 Main :

1.2 Second :

1.3 Objective elements of physical examination and investigation (please **attach copy** of recent results, x-rays, ECG or other tests and exams) :

Weight : lb kg Height : pi/po m/cm Most recent blood pressure :

1.4 Severity of symptoms (S = Slight, M = Medium, I = Intense)

	S	M	I		S	M	I

2. TREATMENT

2.1 Drugs - Name - Dosage :

2.2 Additional treatments (specify type and frequency) :

2.3 Surgery (date, nature and intervention) :

2.4 Hospitalization : From To Name of the hospital :

2.5 Consultation of a specialist: No Yes → *Attach the copy*

3. IDENTIFICATION OF THE PHYSICIAN

3.1. Name, Surname : Telephone : ( )

3.2. License number : Facsimile : ( )

General practitioner Specialist Specify :

SIGNATURE : **DATE :**

NORTH AMERICA
T +1 438 380 7080
Toll-Free +1 877 570 7080

EUROPE
T +33 9 70 73 22 47

MIDDLE EAST
T +961 9 223 994
M +961 76 777 717

AFRICA
T +225 22 52 29 25

info@siassistance.com
siassistance.com