Medical certificate

Group Insurance (Health Care)

This certificate wants to inform the medical advisor of AG Insurance about the nature of the treatment given to the patient and the duration and degree of the incapacity for work.

This document should be filled in by the treating physician.

In case of childbirth, you should only fill in the first part.

Please send this document to:

AG Insurance
To the attention of the medical advisor
Medical Service Health Care – 1JQ5B
Bd E. Jacqmain 53, 1000 Brussels

CONFIDENTIAL

1. To be filled in by the insured in all cases

Group no: ..... and/or contract no. or reference if known: .....

Details of the insured: Last name: ..... First name: .....

Date of birth: ..... / ..... / .....

To be filled in, in case of childbirth

Start date of maternity leave: ..... / ..... / .....

Exact date of childbirth: ..... / ..... / .....

End date of maternity leave: ..... / ..... / .....

2. To be filled in by the doctor

To be filled in, in case of sickness

Diagnosis and/or symptoms of the disorder: .....

Since when have you been treating this patient for this disorder or accident? ..... / ..... / .....

When did the first symptoms appear? ..... / ..... / .....

Has the patient been treated by another physician?

- for a pre-existing disorder? ☐ No ☐ Yes If yes, name and address: .....
- for a current sickness? ☐ No ☐ Yes If yes, name and address: .....

Is or was the patient hospitalised? If so, where? (name and address of hospital):

.....

Start date of hospitalisation: ..... / ..... / ..... Expected duration: .....

Has the patient undergone or will the patient have to undergo surgery? ☐ No ☐ Yes

If yes, what is the nature of the intervention (provide medical code if known): .....

Date (or expected date): ..... / ..... / .....

0079-81415311E-01102018

To be filled in, in case of accident

Date of the accident: ..... / ..... / ..... at ..... : ..... am/pm

Nature of accident: ☐ Private ☐ Work ☐ Road ☐ Sport ☐ Other: .....

Please provide a detailed description of the injury (nature, area, extent, etc. ...): .....

.....

Start date of incapacity for work:

..... / ..... / ..... (exact date) Expected date of return to work: ..... / ..... / .....

Please indicate if incapacity for work is total ☐ No ☐ Yes,
expected duration: ..... (from start date of incapacity)

If not, what is the degree of incapacity? ..... %
expected duration: ..... (from start date of incapacity)

In your opinion, what will be the evolution of the incapacity for work?

.....

.....

.....

Done at ....., on ..... / ..... / .....

Insured's signature: Physician's signature and stamp:

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