CONFIDENTIAL MEDICAL CERTIFICATE (CMC)

XPLORASSUR
Bien plus que vous assister

TRIP CANCELLATION

This document must be completed and signed by the attending physician or any other sworn medical authority at the request of the patient, and by the insured himself/herself for the purposes of coverage under a travel insurance contract.

This document is required for your claim to be processed.

In order to speed up the processing of your claim, this questionnaire must be completed accurately and completely.

Yellow: to be completed by the insured
Blue: to be completed by the doctor

TO BE COMPLETED BY THE INSURED

N° COMPENSATION FILE : S…………………….. (S + 8 FIGURES)

PATIENT

Name		**First Name**		**Age**	

Employee :		**Self-employed person :**	
☐ Yes	☐ No	☐ Yes	☐ No

Pensioner :			
☐	Yes	☐	No

Should the patient take part in the trip ?			
☐	Yes	☐	No

If no, please indicate the relationship to the traveler(s) :					
☐	Spouse, Partner	☐	Children, Grandchildren	☐	Parents, Grandparents
☐	Brother, Sister	☐	Friend	☐	Professional replacement
☐	Other (please specify) :				

TO BE COMPLETED BY THE DOCTOR (medical confidentiality)

(or any other sworn medical authority)

MEDICAL REASON FOR INABILITY TO TRAVEL

Pathology causing the cancellation (obligatory information)	
Date of contraindication to travel or engage in activities (obligatory information)	
Treatment prescribed + attach copy of prescription	

Hospitalisation		Cessation of all professional activity	
☐ Yes	☐ No	☐ Yes*	☐ No **
Start date		Start date	
End date		End date	
If programmed	Date of decision :		

* If yes → Please send us the medical certificate

**If no → Please send us any documents proving your status (proof of pension payment, certificate of education, Kbis extract, Unemployement certificate etc.).

If you are on holiday at the time of cancellation → Please provide us with a validation of your leave by your employer

ANTECEDENTS, HISTORY OF THE DISEASE

Main antecedents in relation to the reason for cancellation	
Date of relapse	

SIGNATURE & STAMP OF DOCTOR AND POLICYHOLDER

The doctor or medical authority :

Date :

Signature :

Doctor's stamp :

From the insured :

Date :

Signature :

This document is strictly confidential and complies with the rules laid down by the insurance company as part of our mission as claims management delegate.