CONFIDENTIAL MEDICAL CERTIFICATE (CMC)

TRAVEL CANCELLATION

This document should be filled in, signed and stamped by your referring physician or any other sworn medical authority, and by the insurance policy holders themselves.

This document is mandatory for your claim to be processed

In order to process your claim faster, this form must be filled in precisely and exhaustively.

Yellow : to be filled in by the insurance policy holder
Blue : to be filled in by the physician

THIS PART MUST BE FILLED IN BY THE INSURANCE HOLDER

COMPENSATION FILE NUMBER : S……..

PATIENT

Last name		**First name**		**Age**	

Employed :		**Self-employed :**	
☐ Yes	☐ No	☐ Yes	☐ No

Retired :			
☐	Yes	☐	No

Was the patient supposed to go on the trip ?			
☐	Yes	☐	No

If not, please indicate your relationship with the patient :

☐	Spouse, concubine	☐	Child, grandchild	☐	Parent , grandparent
☐	Brother, sister	☐	Friend	☐	Professional substitute
☐	Other (please precise) :				

THIS PART MUST BE FILLED IN BY THE PHYSICIAN (medical secret) (or any other sworn medical authority)

MEDICAL REASON FOR IMPOSSIBILITY TO TRAVEL

Medical condition causing cancellation (mandatory)	
Date on which the patient was informed of the impossibility to travel (mandatory)	
Prescribed treatment, or attach a copy of the prescription	

Hospitalization		**Cessation of all activities (Professional or any elementary activity)**	
☐ Yes	☐ No	☐ Yes	☐ No
Start date		**Start date**	
End date		**End date**	

MEDICAL HISTORY

Patient history elements related to the reason for cancellation	
Relapse date	

SIGNATURE & SEAL OF THE PHYSICIAN AND POLICY HOLDER

The physician or medical authority :

Date :

Signature :

Seal of the physician :

The insurance policy holder :

Date :

Signature :

This document is strictly confidential and meets the rules set by the insurance company as part of our mission of insurance claims management.