CLAIM FORM
Non-appearance

I, undersigned, ...

Authorize my doctor to answer the questions put below by the insurance doctor counsellor.
I will personally transmit the hereby document **by post or by email** to the following address: jhallade@me.com

Postal address: Dr Jean HALLADE MASSU, 66, rue Spontini - 75116 PARIS - FRANCE
Tel : 01 48 42 30 67

Signature:

I, undersigned, Doctor: .....

Attending Doctor of the following patient: .....

Since: .....

CERTIFY:

He/she is TEMPORARILY AND TOTALY unable to practice any professional activity:

from ..... to .....

He/she is TEMPORARILY AND TOTALY unable to practice his/her professional activity:

from ..... to .....

ensuing :

☐ **disease**, whose first symptoms have appeared on .....

☐ **accident**, occurred on .....

☐ **traffic accident**, occurred on .....

☐ **pathological pregnancy**. start date: .....

delivery estimated time: .....

Date of the first consultation related to this symptomatology: .....

How long has he been under treatment for this affection ? .....

Condition of the disease and of the undertaken treatment:

.....

.....

.....

Has there been any previous problems related to that affection – if yes, on which date ? .....

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Has there been a follow-up for any other affections – if yes, on which date ?

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Is there an disability to schedule ? .....

Any comment :

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Done in: ..... on the: .....

Signature and stamp of the Doctor:

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