MetLife

ATTENDING PHYSICIAN´S STATEMENT NOTIFICATION OF ACCIDENT OR ILLNESS

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MetLife Europe d.a.c.
Irská společnost s reg. č. 415123
20 on Hatch, Lower Hatch Street, Dublin 2, Irsko
MetLife Europe d.a.c., pobočka pro Českou republiku
Purkyňova 2121/3, 110 00 Praha 1, IČ: 03926206
Zapsaná v OR vedeném MS v Praze | sp. zn. A77032
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Please complete the form by hand (not in black ink) or electronically.

First name and surname of the Insured

Date of birth

Date of the accident/first symptoms of the illness

Time

Place of the accident

Date of first medical examination

Time

Name of the physician and address of the healthcare facility

Diagnosis of injury/illness (code)

Detailed description of bodily injury caused by the accident (e.g. in case of a wound, the length and placement; in case of a burn, the extent and degree; in case of dental injury, the tooth number and whether the injury resulted in tooth loss or loss of vitality; etc.); in case of the illness, please describe its origin and development:

X-ray results with description or other special examination (CT, MR, etc.) – attach a copy of the report or write down medical conclusions:

Description of medical intervention/treatment method (date and type of operation, etc.):

Hospitalization from

to

Where

In case of extension of usual treatment period, please state reasons (describe complications):

Period of inability to work from

to

Total treatment period from

to

Confirmation of inability to work issued by (name of the physician):

Date of issue

Cause of injury given by the Insured during the first medical examination:

Does the bodily injury correspond to circumstances given by the Insured? ☐ yes ☐ no

Was it intentional self-inflicted injury? If so, please provide details: ☐ yes ☐ no

Please complete the following page.

Was the accident investigated by the police? ☐ yes ☐ no

Has the injury or do you anticipate that the injury will have permanent effects? If so, please state probable extent (restriction of joint movement in degrees and side-by-side comparison, if upper limbs were injured, state if the Insured is right or left handed). ☐ yes ☐ no

In case of a facial scar give the length and appearance.

Was the injured part of body impaired prior to the current injury? Did the Insured have the same or similar illness in the past? ☐ yes ☐ no

If so, please provide the date and description of previous injury or illness:

Was the Insured under influence of alcohol or other addictive substances at the time of accident? Is the illness connected with consumption of alcohol or addictive substances? If so, please give details (symptoms, blood-alcohol test result, etc.): ☐ yes ☐ no

If the Insured was officially recognized to be disabled of third degree, please provide the date of origin of such a disability and the reason (basic diagnosis pursuant to the SSA Disability Assessment):

Other information from attending physician:

In case of hospitalization, please attach a copy of hospital discharge report.

Name of the physician, name and address of the healthcare facility, telephone, e-mail:

Date, stamp and signature of the physician

Supplemental information