Assuria
VERZEKERINGEN

REQUEST FORM SECOND MEDICAL OPINION

Information insured/applicant

Name: *[name insured]*	Name applicant: *[name applicant]* ....
Firstname(s): *[firstname insured]*	Policynumber: *[policynumber active AZPAS insurance]* ....
Date of birth: *[date of birth insured]*	Desired inception date **Second Medical Opinion**: ....

Special conditions Second Medical Opinion.

This benefit is **<u>not</u>** available if:

- the insured is hospitalized, being treated in the emergency department (ED) or has to undergo a planned operation at the moment of request for a second medical opinion;
- the insured has not received a previous diagnosis and/or treatment plan, *"First Medical Opinion"*, in relation to the current application for a second medical opinion;
- a treating physician has not evaluated the insured in the last 12 months in relation to the current application for a second medical opinion;
- the insured needs immediate medical assistance;
- the insured needs a physical medical evaluation at the time a second medical opinion is requested.

Authorization to request additional medical information.

- I am aware that Assuria may request an additional medical examination if necessary. This depends on the medical information already obtained. I hereby agree to an additional medical examination.
- I hereby authorize the Medical Advisors of Assuria to request my personal medical information from all physicians, hospitals, clinics or any other medical institution, who have treated me or will treat me in the future.

I, the undersigned, hereby declare that I have taken note of the above-mentioned special conditions associated with the Second Medical Opinion.

Place and date,

[Signature insured]

Place and date,

[Signature applicant]