



Sworn statement regarding travel expenses other than ambulance costs and not reimbursable by compulsory insurance (only in the event of serious illness)

Insured person's identification :

Last name* :
** Or attach a mutual insurance sticker*

First name* :

National number* :
 (if not available, enter date of birth)

Bank account number :

Name of doctor or healthcare facility	Date of visit	Number of km round trip	Stamp or signature of the doctor or center

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Certified sincere and true, Done at , on **Signature**