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2006/AH

Masterkey²Health

CROSS-BORDER HEALTH & ASSISTANCE

Attestation

To fill in by the Health Fund (*Krankenkasse – Mutuelle – Ziekenfonds*) of the country entitled for Social Security, or other official Health Institute (*DOSZ/OSSOM, CFE, Health Fund EU-civil servants*)

Undersigned, _____,
declare that,

(name) _____,

affiliation number _____,

is compulsory* insured with the Health Fund/Insurer/Institute*

(stamp)

Country _____

Commencement date (dd-mm-yy) : _____

Statute or category

- Worker
- Employee
- Self-employed
- Dependant
- Other, _____

Cover:

Waiting period

<input type="checkbox"/> Hospitalisation – Inpatient*/Daypatient Costs*	_____ %	_____
<input type="checkbox"/> Ambulatory – Outpatient Costs	_____ %	_____
<input type="checkbox"/> Medication	_____ %	_____
<input type="checkbox"/> Routine Dental treatment Costs	_____ %	_____
<input type="checkbox"/> Special Dental treatment Costs (Dentures, Orthodontics...)	_____ %	_____
<input type="checkbox"/> Glasses and lenses	_____ %	_____
<input type="checkbox"/> Hearing aids	_____ %	_____
<input type="checkbox"/> Medical Costs abroad	_____ %	_____
<input type="checkbox"/> Repatriation	_____ %	_____

Remarks: _____

Name, function _____ Date _____

Signature _____

* strike out what not matches