

## Aevitae

P.O. Box 2705 6401 DE Heerlen

## **Declaration Form for Travel Costs of Seated Patient Transport**

Insured person								
Forname and surname:  Address:  Postal code:  Phone number:		Policy number:  House number:  Town/city:						
						Date of birth:		
						What are the costs to do wi	th? n for all destinations and periods?	O Yes
		If not, please apply for this no	ow using the Form for Medical Declaration of S	eated Patient Transpor	t via <u>www.aevitae.com</u> .			
Transported by								
O Own transport	We will use the route planner for the number of kilometres travelled.  (No reimbursement for parking costs)							
O Public transport	Please enclose the train tickets and/or travel and transaction summary.							
O Taxi	Please enclose the original taxi receipts.  (On the taxi receipts must be shown who was transported on what date and the departure and arrival points.)							

In all cases, please enclose the appointments card. If you send in your travel declaration, please ensure that the enclosed appointments card is provided with a signature and stamp from your treatment location.

## Transported from and to

Date of transport	From (name of institution and postal code)	To (name of institution and postal code)	Amount for public transport or taxi	Journey out km	Journey back km

Date of transport	From (name of institution and postal code)	To (name of institution and postal code)	Amount for public transport or taxi	Journey out km	Journey back km
reimbursement c enclose the origi	s only possible if you have received aut of the authorised travel costs, it is neces nal appointments card or a written decl nointments, a copy will suffice.	sary that you complete this form in full	. It applies to all mea	ans of transport	that you must
Undertaking					

The undersigned declares that the form has been completed truthfully. I know that incorrect/partial completion of this form or concealment of facts relevant to the insurance policy/policies could lead to the declaration being invalidated. By signing, I give permission if necessary to seek information from the doctor/specialist treating me to verify my declaration.

Date:	Signature:

Send the fully completed and signed form with the enclosures in to:

Aevitae

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