GENERAL HEALTH INSURANCE COMPANY OF THE CZECH REPUBLIC

Affidavit on indicated treatment

I, the undersigned:

name and surname
.....

date of birth
.....

a) hereby declare that[1]:

□ I have undergone radiation therapy

□ I have a diagnosis of alopecia[2]

b) hereby declare that the insured person (name and surname of the child, date of birth)

.....

of whom I am[3] a legal representative, guardian, foster parent, adoptive parent, custodian[4]

□ has undergone radiation therapy

□ has a diagnosis of alopecia[5]

In ..... on .....

.....

Signature of the declarant

[1] Mark valid with a cross
[2] Including alopecia caused by cancer treatment (anticancer chemotherapy/radiotherapy).
[3] Delete as appropriate.
[4] Mark valid with a cross
[5] Including alopecia caused by cancer treatment (anticancer chemotherapy/radiotherapy).