10. számú melléklet

Költségvállalási nyilatkozat (angol)

DECLARATION OF COMMITMENTS

Surname of the insured: ……...
First name of the insured: …….
Date of birth of the insured: …….

Passport number of the insured: ……...

Clinical department where planned treatment to be carried out:
……...

Treatment is planned in: outpatient care / inpatient care

Reference of outpatient / inpatient care planned treatment is based on:
…….....

Diagnosis: …….....
Responsible party: Insurance account:…….

Percentage of cost to be covered by insurance company

Will additional, extra cost be covered? yes / no

If yes, further details: ……...

Contact person's (at the insurance company) e-mail address
……...

Fax number: …….
Telephone / mobile number: ……

Date: ……

signature of the insured ……

signature of the authorised person at the

insurance company ……

official stamp of the insurance company

……..