Release 01.09.2014

Health insurance or cost carrier

Surname, first name of the insured

born on

Cost unit identification | Insured person number | status

Establishment No. | Doctor No. | Date

For the purpose of proving this to the health insurance company
(when applying for maternity benefit), I hereby certify that

that the insured person named above
is expected to give birth on DDMMYY

I issue this certificate based on the
examination I conducted on DDMMYY

Special findings, if applicable

Testimony about the presumed day of childbirth

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Copy for the health insurance company

Binding template

Contract doctor's stamp / doctor's signature

The insured person must complete the form before submitting it to the health insurance company.

Name first Name

birth date DDMMYY

Postcode

Place of residence

House no.

Account holder

IBAN

Financial institution

BIC

Information on employment I am currently

employed, at

terminated / limited to DDMMYY

Address of the employer

self-employed

unemployed

Artist / Publicist

Explanation:
I will inform my health insurance company immediately of any changes to my information. If the expected due date is changed, I will inform my health insurance company and my employer or the employment agency.

Date DD MM YY

Binding template

Signature of the insured