



GEBA Emergency Travel Benefits Plan Physician's Statement

Solutions today for a secure financial tomorrow.

Please return this form to: GEBA, P.O. Box 206, Annapolis Junction, MD 20701-0206.

Call us with questions at (301) 688-7912 or (800) 826-1126.

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN, OR OTHER PERSON WHO HAS ATTENDED/EXAMINED ME AND/OR MY FAMILY MEMBERS TO DISCLOSE WHEN REQUESTED TO DO SO BY THE GOVERNMENT EMPLOYEES' BENEFIT ASSOCIATION, INC., OR ITS REPRESENTATIVES, ANY AND ALL INFORMATION WITH RESPECT TO ANY ILLNESS, INJURY OR MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL OR MEDICAL RECORDS. A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL.

Claimant's Name: _____ Date: _____

Signature of Claimant: _____ Date: _____

Attending Physician's Statement

Patient's Name: _____ Age: _____

Nature of Illness/Injury: _____

Was this a pre-existing condition? Yes No

Date the symptoms first appeared or accident occurred: _____

Date of your first treatment of the patient: _____

Was the patient treated by anyone else? Yes No

If so, by whom? _____ When? _____

In your opinion, was the above illness/injury serious enough to require attendance of the claimant named above?

Yes No

If yes, please explain: _____

Attending physician's name: _____ Date: _____

Signature of Physician: _____ Date: _____

Physician's address and phone number: _____