



Please return completed form to:
 GEBA, Inc.
 P.O. Box 206
 Annapolis Junction, MD 20701
 Or fax: (301) 688-6694
 Or email: geba@geba.com

Member Number
 (if unknown, leave blank)

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

Emergency Travel Plan (ETP) Physician's Statement

I hereby authorize any hospital, physician, or other person who has attended my family member to disclose when requested to do so by the Government Employees' Benefit Association, Inc. (GEBA), 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 (if necessary).

Claimant's Name:

Signature: _____ Date:

Attending Physician's Statement:

Patient's Name: Age:

Nature of Illness/Injury:

Was this a preexisting 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?

Please specify the date (approximate) of the patient's most recent decline in health:

In your opinion was this recent decline in health serious enough to require the attendance of the claimant named above? Yes No

If yes, please explain:

Attending Physician's Name:

Physician's Signature: _____ Date:

Physician's Address:

Physician's Phone Number: