



Versicherungsanstalt öffentlich Bediensteter

Questionnaire 1 (to be completed by the insured person)

Insured person:

Social Security no.:

First and last name:

Social security no. and date of birth:

Please check as appropriate.

1. How long has the condition existed?

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2. What schooling does your child have?

Type from - to Qualification

.....
.....
.....
.....

3. What (temporary) jobs has your child had up to now?

Type from - to

.....
.....

4. Is your child currently in employment?

yes no

Since when?

Where? (Name of employer)

5. Are you in receipt of increased child benefit for your child?

yes no

If yes, please send us a copy of the child benefit confirmation.

6. Is your child in receipt of a pension?

yes no

Monthly amount? EUR

From which provider?

7. Is your child in receipt of any other income?

yes no

Monthly amount? EUR

.....
Date and signature

Telephone number (for any queries):

Questionnaire 2 (to be completed by the attending physician)

Medical examination

Patient's first and last name:

Social security no. and date of birth:

Please check as appropriate.

1. Medical history:

- a) Illnesses overcome:

- b) Start of the symptoms of the current condition:

- c) Progress of the current condition:

- d) Treatment and treatment successes:

2. Report:

- a) Somatic, accounting particularly for evident deficiencies and their impact on performance:

- b) Psychologically, accounting particularly for psychological capacity

3. Diagnosis:

4. Is the current condition to be seen as temporary or permanent?

5. Does the condition require treatment? (medical treatment, institutional care, medical aids) yes no

6. Is the patient able to work? yes no

Which areas?

7. Has the ability of the patient to work been fully or partially impaired, temporarily or permanently? (circle as appropriate)

8. It is possible for the patient to return to work after receiving training or treatment? yes no

.....
Date, stamp and signature

Telephone number (for any queries):