

¹ Mark valid with a cross

Physician's confirmation of diagnosis

| I hereby confirm that the following insured person of VZP CR: |
|---|
| name and surname |
| date of birth |
| has been diagnosed sincewith1 |
| |
| □ diabetes mellitus |
| □ celiac disease |
| □ a low protein diet for rare inherited metabolic defects |
| name |
| code |
| |
| Inon |
| |
| |
| Signature and stamp of the physician |