

# Medical Certificate

Claim Ref:

This certificate is to be completed by the registered General Practitioner (GP) of the person whose illness/injury/death has caused the claim.

- Note
- Any charge made for its completion is the responsibility of the claimant and is not refundable under the policy.
  - Please answer all questions. Ticks, dashes, N/A are not acceptable. Please complete in CAPITALS.
  - All information is treated as Private and Confidential

1. Name of the person whose condition has caused the claim whether the traveller or not:	<input type="text"/>	2. Date of Birth:	<input type="text"/>
3. Are you the usual GP: <input type="checkbox"/> Y <input type="checkbox"/> N	4. GP name:	5. If yes, for how long:	<input type="text"/>
6. If no, what is your involvement:	<input type="text"/>		
7. Do you have the patients medical notes: <input type="checkbox"/> Y <input type="checkbox"/> N	8. Onset date of symptoms:	<input type="text"/>	
9. Give full description of illness or injury:	10. Date first consulted:		<input type="text"/>
<input type="text"/>	11. Date of diagnosis:		<input type="text"/>
<input type="text"/>			

12. In date order, set out the patient's medical history relating to the condition causing the claim. Please include all associated conditions. If no history, state NONE.


13. Does the person suffer from HIV/Aids/psychological disorder/depression/anxiety?  Y  N  
If yes, indicate which and provide details:

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14. Pregnancy:

a) Date Confirmed:  b) LMP  c) ECD

d) Please provide the exact reason for not travelling:

15. At the time that the insurance was purchased, was the person receiving, or on a waiting list for, or recovering from in-patient treatment in a hospital/nursing home:

<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="text"/>
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16. The date when it became apparent that the travel arrangements should be cancelled:

17. The date when you advised the need to cancel the travel arrangements:

18. If the patient is the traveler

(i) when would they be fit to travel again:

(ii) have they been signed off work:  Y  N From  To

19. Please provide the patient's state of health at the time the holiday was purchased:

20. Please certify that solely due to the reason detailed in (q9) it is necessary for the travel arrangements to be cancelled or cut short:

<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="text"/>
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## GP DECLARATION

I have examined the patient and/or referred to their medical records and declare that the information given is correct and no relevant details have been withheld.

GP Name:	<input type="text"/>
GP Signature:	<input type="text"/>
Date Signed:	<input type="text"/>

Surgery Stamp

<input type="text"/>
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