

MEDICAL CERTIFICATE [side 1 of 2]

Claims reference number:

TO THE GENERAL PRACTITIONER OF THE PERSON CAUSING THE CANCELLATION OR CURTAILMENT: Please complete both sides of this form in full, in black ink and in block capitals. Any fee due is the responsibility of the claimant. **IF YOU ARE THE PATIENT'S SPECIALIST OR CONSULTANT, PLEASE GIVE THIS FORM TO THE PATIENT'S GP FOR COMPLETION.** *If any sections on this or any related form are left blank or are unclear, your claim may be delayed.*

1. Full name of the person to whom these medical details apply	3. Please state the exact nature of the illness/accident which has made cancellation or curtailment of the holiday necessary.
2. Date of birth	
4. On what date did the named patient first receive consultation about this condition?	5. On what date was the condition first diagnosed?
6. On what date was the cancellation or curtailment first deemed necessary?	7. Were you aware of the holiday plans when first consulted? If no, please confirm the first date on which the cancellation or curtailment could have been reasonably anticipated.
8. Does the condition fully prevent the patient from travelling? If not, please describe to what extent.	9. If you were consulted prior to departure, would you have advised against travel?
10. Has the named patient suffered from the condition detailed in box 3 or anything similar, in the past? If yes, please give FULL DETAILS including DATES.	
11. Is the named patient under investigation or awaiting results for any existing diagnosed or undiagnosed medical condition? If yes, please give FULL DETAILS.	12. Was/is the patient on a waiting list for any in- or out-patient treatment? If yes, please give FULL DETAILS.
13. If applicable, at the time the Insurance was issued and/or at the time the holiday was booked, please state whether or not the condition was under control.	
14. At the time the Insurance was issued and/or at the time the holiday was booked, please state whether or not the patient had received treatment / consultation or medication in the 6 months prior. If yes, please give FULL DETAILS.	

FOR CLAIMS RELATING TO DEATH

Please confirm that, to the best of your knowledge and belief, the cause of death of the person named above was as stated below:

I - Disease or condition directly leading to death*

Antecedent causes

Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last

II - Other significant conditions contributing to the death, but not related to the disease or condition causing it

Approximate interval between onset and death

YEARS MONTHS DAYS

a)

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b)

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c)

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d)

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* This does not mean mode of dying, such as heart or respiratory failure; it means the disease, injury or complication that caused death

MEDICAL CERTIFICATE [side 2 of 2]

Claims reference number:

15.1. Has the patient been referred to a consultant specialising in the relevant field?	15.2. On what date was the patient referred?
15.3. Consultant's full contact details	15.4. On what date did the consultant diagnose the condition?

16. Do your records contain any past or present history of the following:	Yes/No	Dates	Full Details (including your comments on stability of condition)
MUSCULOSKELETAL DISEASE			
MALIGNANCY			
THROMBOEMBOLISM or THROMBOSIS			
CARDIAC DISEASE/HYPERTENSION			
PULMONARY DISEASE			
HEPATIC DISEASE			
RENAL DISEASE			
ENDOCRINE DISEASE			
GASTROENTEROLOGICAL DISEASE			
NEUROLOGICAL DISEASE/EPILEPSY			
GYNAECOLOGICAL DISEASE/UROLOGICAL			
DIABETES			
ALCOHOL OR DRUG USE			
ALLERGIES			
PSYCHIATRIC DISEASE			
BREAST DISEASE			
IMMUNOLOGICAL DISEASE			

17.1. For Pregnancy only: date of LMP	17.2. Date pregnancy confirmed
17.3. Exact medical condition within pregnancy	17.4. Estimated date of confinement

I certify that the cancellation or curtailment was solely due to the reasons stated on this form.

GP's name & signature:

Qualifications: _____

DATE THIS CERTIFICATE COMPLETED: _____

OFFICIAL PRACTICE STAMP

CLAIMANT'S DECLARATION: I declare that the statements on this form are true and correct to the best of my knowledge and belief and no information has been withheld. The Insurer does not admit liability by the issue of this form.

Claimant's full name _____ Claimant's signature _____ Date _____

Claimant's address _____