Medical Certificate

This **must be** completed by the **Registered General Practitioner** (GP) of the person whose illness/injury/death has given rise to the claim. Any charge made for the completion of this certificate is the responsibility of the insured and is not refundable under the insurance policy. Please ensure the GP answers all relevant questions. Ticks, dashes, N/A etc will not be acceptable. This information will be treated as private and confidential. A certificate not containing the specific information requested will not normally suffice.

Full name of patient **Date of Birth** / /

Are you the regular medical attendant/ from the same practice: Yes ☐ No ☐ **If yes, for how long**

If no, what is your involvement with this matter

State precise nature of the medical condition/illness/injury/cause of death, that gives rise to this claim

If injury, state how this was caused

If claim is result of pregnancy: **Date pregnancy confirmed** / / **LMP** / / **EDC** / /

Has patient suffered from the same or related condition in the past five years: Yes ☐ No ☐ **If yes, for how long**

State the exact date of onset of symptoms of conditions / / **Date first consulted** / /

Date of any serious deterioration/exacerbation, if applicable / /

What ongoing medical condition(s), or medical complication directly attributable to the condition(s), were being investigated by a registered medical practitioner at:
Date trip insurance was purchased / / **Date trip was booked** / /

Is the illness/injury attributable to drugs, alcohol or HIV or HIV related illness, including AIDS: Yes ☐ No ☐

Give Details

Has the person named above received a terminal prognosis: Yes ☐ No ☐

If yes, what date was the terminal prognosis given to: **The patient** / / **The claimant** / /
(if not the same person)

Has the patient been referred to or seen by a hospital doctor or surgeon or needed inpatient treatment for this or any related condition within 12 months prior to the date the trip insurance was purchased? If so, please give full details including dates

If the patient was booked to travel did they consult you prior to booking or travelling regarding the advisability of undertaking the holiday or journey:

Yes ☐ No ☐ **If yes, on what date** / /

If no, when would you have advised cancellation had you been aware of the planned trip

If the patient travelled, were they fit to travel the date of departure

Provide details of patient's state of health at the time the insurance was purchased and date of booking the trip

State exact reason for cancellation

Please advise the date when it first became apparent that the holiday should be cancelled / /

Please state the exact date you advised the need to cancel / /

Are you prepared to certify that, soley due to the condition described above, the claimants are compelled to cancel their holiday arrangements:

Yes ☐ No ☐

To be completed by the usual Registered General Practitioner (GP): I have examined the patient and/or referred his/her medical records and I declare that the information given is correct and that no details relevant to the case have been omitted.

Name **Qualifications**

Sign **Date** / /

Surgery Stamp