MEDICAL CERTIFICATE

Section 1: To be completed by the claimant

I hereby authorise the below-named Doctor and or his/her practice to release any information required by Insurers and/or their appointed Loss Adjusters to deal with my claim. I understand that this document is to be completed at my own expense and that I am unable to recover these costs as part of my claim.

Full Name ……..……..... Signature ……..…… Date ……

Section 2: To be completed by the regular medical attendant of the person whose injury/illness gives rise to the claim.

1. Full name of patient: …… Date of Birth ……..	
2. Are you the regular medical attendant? If **YES**, for how long have you been the medical attendant? if **NO**, please state your involvement in this matter?	**YES** / **NO** …….....……
3. Please state precise nature and cause of: Medical condition/illness/injury/death: ……..	
4. a) Please state the exact date of onset as in 3. b) Date first consulted. c) Date when there was any deterioration, if applicable.	a) b) c)
5. Was patient waitlisted for hospital admission? If yes, state a) date waitlisted b) date admitted	**YES** / **NO** a) b)
6. Please give details of any previous medical history which has a bearing on the condition in 3. above: ……..	
7. Please state whether, at the time that the holiday was booked, the patient was in your opinion: a) fit to travel b) undergoing medical treatment If **YES** to b), what treatment was given and was it reasonable for the patient to still continue with their travel plans?	a) **YES** / **NO** b) **YES** / **NO** ……
8. Please state whether, at the time that the balance of the holiday became due, the patient was in your opinion: a) fit to travel b) undergoing medical treatment If **YES** to b), what treatment was given and was it reasonable for the patient to continue with the travel plans?	**YES** / **NO** **YES** / **NO** ……
9. Please confirm the state of the patients health at the time the Insurance was effected …….. ……	
10. If the cancellation is as a result of pregnancy, what is the E.D.D and reason for cancellation advice? ……..	
11. Please advise the date when it first became apparent that the holiday should be cancelled.	
12. Please state the exact date you advised the need to cancel.	
13. Are you prepared to certify that solely due to the condition described in 4 above, the claimant(s) are/were compelled to cancel their holiday?	**YES** / **NO**

I hereby certify that the information given is correct. Name …….....Qualifications ….....

Practice Address……. Signature….……

***Note to the Medical Attendant**

This document must be stamped with an official authorisation stamp as confirmation of authenticity. Date ……