MEDICAL CERTIFICATE

Claim Number | | | | | | | | | | **(for office use only)**

This certificate is to be completed in **BLOCK CAPITALS** by the usual treating GP of the person causing the cancellation or curtailment. If there is insufficient space for your answers please use the Additional Information box provided. Medical Certificates completed by a hospital will not be accepted.
Note: any fee incurred to complete the Medical Certificate may not be considered by the policy.

Name of patient: | Age: | Date of Birth: D D M M Y Y

Are you the patients usual GP: ☐ Yes ☐ No How long has the patient been with the practice: ☐ Years ☐ Months

Precise nature of illness/injury causing cancellation/curtailment of the holiday/trip:

Are you prepared to certify that solely due to the condition described above, the claimant(s) are compelled to cancel/curtail? ☐ Yes ☐ No

Is the above condition directly or indirectly related to any known pre-existing condition? ☐ Yes ☐ No

If yes, please provide details of the condition:

Date illness / injury causing your claim: D D M M Y Y

Date & time you were first consulted: ☐ hrs D D M M Y Y

Date referred to a consultant (if applicable): D D M M Y Y

Date wait listed for operation (if applicable): D D M M Y Y

Date admitted to hospital (if applicable): D D M M Y Y

Date discharged from hospital (if applicable): D D M M Y Y

Claims due to pregnancy

Date confirmed: D D M M Y Y

Expected due date: D D M M Y Y

The reason why the pregnancy necessitates cancellation/curtailment of the holiday/trip:

Date you advised the patient to cancel/curtail: D D M M Y Y

If you did not advise the patient to cancel/curtail, on what date did this become medically necessary? D D M M Y Y

If possible, please indicate when the patient would be fit to travel? D D M M Y Y

Has a terminal prognosis been made? ☐ Yes ☐ No If yes, when was the patient made aware of this? D D M M Y Y

In the last 12 months has the patient been fit and well enough to travel? ☐ Yes ☐ No

If no, please provide details:

Were you advised of the planned trip? ☐ Yes ☐ No

If yes, please provide date: D D M M Y Y

If advised, were there any circumstances which could have reasonably been anticipated to give rise to a claim? ☐ Yes ☐ No

If yes, please provide details:

If the response to any of the following questions is YES please provide details of the Condition and the Date of Diagnosis in the spaces provided. Please use the Additional Information box below if you need more space for your answers.

In the last 5 years has the patient been treated (including prescribed medication) for any:

		D D M M Y Y
- respiratory condition (relating to the lungs or breathing);		
- heart or heart related condition;		
- circulatory condition (relating to the blood or circulation);		
- kidney or renal condition;		
- liver condition;		
- condition relating to the pancreas e.g. diabetes;		
- cerebral or neurological condition (relating to the brain);		
- type of cancer;		
- type of stroke;		
- central nervous system disorder;		
- irritable bowel disease;		
- psychiatric or psychological conditions.		

		D D M M Y Y
Received any surgery, inpatient or outpatient treatment or had any tests or investigations in a hospital or clinic or been seen by a specialist consultant within the last 2 years?		
Been prescribed medication for any medical condition in the last 2 years?		
Has there been any change in medication within the last 6 months?		

Address Stamp

I have examined the patient and referred to their medical records and I declare that the information given is correct and that no details relevant to this case have been omitted.

Name:

Qualifications:

Signature: Date:

Additional Information: