

**MEDICAL CERTIFICATE**  
(to be completed at the claimants own expense)

**SECTION 1: TO BE COMPLETED BY THE CLAIMANT**

I hereby authorise the above-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.

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

I hereby certify that the information given is correct.

Name..... Qualifications .....

Signature ..... Date .....

Address .....

**Please stamp this document with an official authorisation stamp as confirmation of authenticity.**