MEDICAL CERTIFICATE. This Medical Certificate must be completed by the ill/injured/deceased person's usual Doctor (General Practitioner), and **not** any Specialist Doctor he/she may attend. The Medical Attendant is respectfully requested to give as much detail as possible in order to assist the claimant and avoid the necessity of additional enquiries. (The Claimant must obtain this document at his/her own expense).

1 Name of person to whom this Certificate applies.

2 Date of Birth.

3 Are you his/her regular medical attendant? Yes ☐ No ☐

If Yes, for how long?

If No, please indicate in what capacity you attended the patient and for how long.

4 Please state:

a) Precise nature of illness/injury/death.

If claim relates to injury please state how this was sustained.

b) Date of onset of illness/injury.

c) Details of patient's state of health and medical condition on the date the insurance was effected.

d) At the date the insurance was effective, was there any indication of the patient's current condition? Yes ☐ No ☐

e) Date when there was deterioration, if applicable.

f) Date when it first became apparent the claimant would be unable to travel.

g) When did you advise claimant of need to cancel OR postpone?

h) Has the patient previously suffered or received treatment, advice or medication for the same or any related condition? Yes ☐ No ☐

If Yes, please provide the details, including the dates.

5 Was patient wait-listed for hospital admission? Yes ☐ No ☐

If Yes, please state: Date wait-listed. Date of admission.

6 If pregnancy state E.D.D. and reason for cancellation advice.

7 Are you prepared to certify that solely due to the condition described above the Claimant is compelled to cancel OR postpone the holiday/travel. Yes ☐ No ☐

I, **(Medical Practitioner) certify that the foregoing statements are correct.**

Signature: **Date:**

Address:

Qualifications: