Travel Insurance Direct

LLOYD'S

General Practitioner/Dentist Medical Certificate

(Part 1) - To be completed by the person whose state of health caused the claim or Executor/Guardian of that person (if applicable).

I authorise any hospital, physician or other person who has attended me, to give my travel insurance company or its representative, any, or all information, with respect to any sickness or injury, medical history, consultation, prescription, or treatment, and copies of all hospital or medical records. I agree that a photocopy of this authorisation will be considered as effective and valid as the original.

Name of the person whose illness or injury caused the claim:

Their Date of Birth:

/ / (DD/MM/YYYY)

Signature:

(Part 2) - To be completed by your usual General Practitioner/Dentist

This Medical Certificate must be completed at the claimant's expense by the usual doctor (G.P.)/dentist of the person whose illness/injury/death caused this claim.

1. **Name of Patient:**
2. **Their Date of Birth:**

   / / (DD/MM/YYYY)
3. **Does he/she usually attend your practice?**

   No › Go to Question 4

   Yes › If so, how long?
4. **Do you have access to the patient's medical/clinical records?**

   Yes No
5. **Please provide a precise diagnosis of the illness/injury:**
6. **Date of the onset of the illness or injury:**

   / / (DD/MM/YYYY)
7. **Date on which you were first consulted for symptoms of illness/injury:**

   / / (DD/MM/YYYY)
8. **Did you refer your patient to a specialist?**

   No › Go to Question 13

   Yes › If so, Give details:
9. **Name of Specialist:**
10. **Address of Specialist:**
11. **Date Referred:**

    / / (DD/MM/YYYY)
12. **Date First Attended Specialist:**

    / / (DD/MM/YYYY)
13. **Are you aware of referrals to any other Practitioners/Surgeon/Specialist?**

    No › Go to Question 14

    Yes › If so, please provide details
14. **Is the medical condition described caused or exacerbated by, traceable to, or related to any recurring illness or condition?**

    No › Go to Question 15

    Yes › If so, please provide details:

15. Please provide details of all medication that your patient was taking over the past 24 months (regardless of prescribing physician) and the relating condition.

Condition:
Medication:
Condition:
Medication:
Condition:
Medication:
Condition:
Medication:
Condition:
Medication:

16. Please give details of any chronic disease or illness or any physical defect or infirmity from which he/she suffers:

17. Was the patient medically advised not to travel prior to the commmencement of their trip?

No › Go to Question 18

Yes › On what date?

/ / (DD/MM/YYYY)

18. Did your patient travel overseas for the purpose of obtaining medical treatment or advice for medical treatment?

No › Go to Question 19

Yes › If so, please provide details:

19. Please provide a printout of your patient's medical history and clinical notes (if applicable).

Doctor's Declaration

I declare that I have examined the patient named above and/or have referred to their medical records and confirm that the information given is a true and correct statement.

Name of Doctor/Dentist:

Signature:

Email:

Phone:

Fax:

Doctor's Stamp: