Medical Certificate

Please note section (A) is to be completed by claimant, section (B) is to be completed by the General Practitioner of the person whose death, illness or injury caused this claim.

Note : any charges for completion of this form are the responsibility of the claimant.
Note : all dates should follow the DD/MM/YYYY format

Section A- claimant to complete

Claimants name		Date of Birth:	
Address:		Post Code:	
Destination		Booking date of trip	
Patients Name/relationship to claimant, if different from above		Date of Birth:	
Address:		Post Code:	

Access to Medical Records
You are responsible for arranging completion of the Medical Certificate below. However, if on receipt of that Medical Certificate it is deemed necessary to obtain a further medical report from the doctor concerned in relation to this claim we may need to ask for further information, or even obtain further information from the doctor ourselves. In order to avoid possible delays in handling your claim, please provide consent from the patient or next of kin as appropriate. Before signing the consent form, the patient concerned should read the following summary of their rights under the Access to Medical Reports Act 1988; a) You can withhold your permission but if you do we will be unable to proceed with your claim if further information is required b) If you wish to see the medical report, you must indicate on the claim form and contact your doctor within 21 days about arrangements to see the report. Whether or not you wish to see the report before it is sent to us, the doctor must let you see a copy for up to 6 months after it is supplied, if you ask c) You can ask the doctor if he/she will amend any part of the report, which you consider to be incorrect or misleading. If the doctor is not in agreement you may append your comments Your doctor can in certain circumstances withhold the report from you, or any part of it.
Consent to obtain a Medical Report to be completed by the patient or next of kin (as appropriate)
I have read the Statutory Rights under the Access to Medical Reports Act 1988 (per the above) and consent to Qover SA obtaining a further medical report from a doctor who has cared for me should it be deemed necessary. In that event I do/do not wish to see (or have a copy of) the medical report before it is sent to Qover SA.

Patient Name:	Signature (Patient):	Date: / /
Doctor's Name:	Address:	

Section B – Medical Practitioner to complete

Please answer ALL questions in full. (N/A or dashes are not acceptable).

Access to medical records	Yes	No

Patients Name:		Date of Birth:
Address:		Post Code:
Please detail the medical condition/injury that necessitated cancellation/curtailment/medical treatment:		

When did the symptoms of this condition begin	
When did the patient first consult for this condition	
When was the date of diagnosis for this condition?	
If this is an exacerbation of a recurring/chronic condition, please advise the deterioration date?	
Was the patient referred to a consultant? If so, please specify the date	
What date was the advice against travel given/when did it become necessary to cancel the trip/arrangements	
Please specify the reason for your advice against travel	
If the claimant did not seek advice, can you confirm if you would have advised against travel, had they have sought advice?	

Was the patient fit and well at the time of booking (please see section A)	Yes	No
If not fit, please confirm the date when this became apparent?		
Is the cancellation due to pregnancy?		
Estimated Date of delivery/confinement		
Date pregnancy confirmed		
What illness/condition connected with the pregnancy gave rise to your recommendation not to travel?		

Medical history

Please confirm any previous medical conditions which have been treated or consulted about in the 2 years prior to booking/insurance purchased		
Medical condition	Date of diagnosis	Medication/treatment

Please confirm whether the patient has ever suffered with any cardiac related conditions?		
Medical condition	Date of diagnosis	Medication/treatment

In your opinion, is the medical condition causing this claim directly or indirectly linked to any of the existing conditions mentioned in the "Medical History" section above?	

Details of the Patient / Your usual General practitioner

Name of Medical Practitioner, position i.e., GP, midwife etc.			
Signature:	Date:		
Surgery Address:		Post code:	
Telephone number:			
Name of hospital admitted to (if applicable)			
Consultant Name (if applicable)			
Stamp			