CLAIM REFERENCE:

URV REFERENCE:

Postcard Claims
1 Tower View,
Kings Hill, West Malling,
Kent,
ME19 4UY
Email:
claims@postcardtravelinsurance.co.uk
Web:
www.postcardtravelinsurance.co.uk

MEDICAL CERTIFICATE

This medical certificate 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.

Doctors Name:

Doctors Qualification:

Telephone Number:

Doctors Signature:

Surgery Stamp

Date: DD / MM / YY

PLEASE ANSWER ALL QUESTIONS IN FULL (n/a or dashes are not acceptable).

Patients name: **Date of Birth:** DD / MM / YY

Patients address:

Post code:

1. **Please detail the medical condition that necessitated this patient to cancel his/her planned trip:**

2. **Is this the first diagnosis of this condition? Yes: No:**

3a. **What was the date of diagnosis for this condition?** DD / MM / YY

3b. **Please advise the date of any previous diagnosis** DD / MM / YY

4. **If this episode is an exacerbation of a recurring or chronic condition, please advise the date of deterioration:** DD / MM / YY

5. **Was the patient referred to a consultant? Yes: No: Date patient seen by consultant:** DD / MM / YY

6. **Please advise if this condition has caused the patient to be hospitalised and the dates involved:**

7. **Date/s of any relevant diagnostic tests and results:**

8. **Was the treatment emergency, elective or expected?**

9. **Has the patient ever suffered from the following medical conditions? If yes, please provide details and dates.**

Any cardiac or circulatory conditions?	
Any respiratory conditions?	
Any type of diabetes?	
Hypertension?	
Stroke?	
Any type of Cancer?	

10. **If the patient has been under this care of a consultant or hospital in the previous two years please give brief details?**

11. **Please list all regularly prescribed medication including inhalers along with date first prescribed:**

Before this illness, injury or death	**After this illness or injury**

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travel claims facilities

ACCESS TO MEDICAL REPORTS ACT 1988

We at Travel Claims Facilities are acting agents on behalf of your insurer, full details are listed within your policy document, if we require information from your doctor in respect of your insurance you have certain rights under the Access to Medical Reports Act 1988:

- Your consent* is required the insurer or anyone acting as their agent can apply for a report and you may see the report before it is supplied to the insurer or their agents, or at any time during the six months after that.
- If you disagree with the contents of the report or consider it to be misleading you may ask your doctor to amend it. If the doctor disagrees you may add your own written comments. The doctor may withhold all or part of the report from you if he/she thinks that this would be in your best interests, or that of others. Alternatively, you can refuse consent*.
- At no time will the report be sent to the insurer or anyone acting as their agent without your consent.

*You can refuse to give your consent however this may mean we are unable to deal with your claim

Charges made by the doctor for providing such a report are for your own account, as they are not covered by this policy.

DETAILS OF THE PATIENTS/YOUR USUAL GENERAL PRACTIONER

Patient Name:

Name of General Practitioner:

Surgery Address:

Post Code:

Telephone Number:

Name of Hospital admitted to (if applicable):

Consultant Name:

DECLARATION

I consent to Travel Claims Facilities or anyone acting as agents for the insurer as detailed within the policy documents, seeking medical information from any doctor who has any at any time attended me concerning anything which affects my/the patient's physical and/or medical health. I authorise the giving of such information during and after my lifetime.

I have been informed of and understand my rights under **Access to Medical Reports Act 1988** (see above).

I do / do not wish to see any report before it is sent: **I do:** ☐ **I do not:** ☐

Patients name: **Date of Birth:** DD / MM / YY

Patients address:

Post code:

Signature of patient or **Signature of next of kin** **Date:** DD / MM / YY

Please print name:

If next of kin, please advise your relationship to the patient: