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.*

Policy Number:					
Doctors Name:		Doctors Qualification:			
Signature:			Date:	DD/MM/YYYY	
Surgery Stamp:			Telephone:		

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

Patients Name:		Date of Birth:	DD/MM/YYYY
Address:		Post Code:	
Please detail the medical condition that necessitated this patient to cancel their planned trip:			

Is this the first diagnosis of this condition?	Yes ☐	No ☐
When was the date of diagnosis for this condition?	DD/MM/YYYY	
Please advise the date of any previous diagnosis:	DD/MM/YYYY	
If this an exacerbation of a recurring/chronic condition, advise deterioration date?		DD/MM/YYYY

Was the patient referred to a consultant?	Yes ☐	No ☐
Date patient seen by consultant?	DD/MM/YYYY	

Please advise if this condition has caused the patient to be hospitalised and the dates involved:
Dates of any relevant diagnostic test and results:
What was the treatment emergency, elective or expected?

Has the patient ever suffered from the following medical conditions? If yes, please provide details and dates:			
Any cardiac or circulatory conditions?		Date:	DD/MM/YYYY
Any respiratory conditions?		Date:	DD/MM/YYYY
Any type of diabetes?		Date:	DD/MM/YYYY
Hypertension?		Date:	DD/MM/YYYY
Stroke?		Date:	DD/MM/YYYY
Any type of cancer?		Date:	DD/MM/YYYY

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

Please list all regularly prescribed medications including inhalers along with date first prescribed:			
Before this illness, injury or death:	Date:	After this illness or injury:	Date:
	DD/MM/YYYY		DD/MM/YYYY
	DD/MM/YYYY		DD/MM/YYYY
	DD/MM/YYYY		DD/MM/YYYY
	DD/MM/YYYY		DD/MM/YYYY
	DD/MM/YYYY		DD/MM/YYYY
	DD/MM/YYYY		DD/MM/YYYY
	DD/MM/YYYY		DD/MM/YYYY

Access to Medical Reports Act 1988

We at tifgroup 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 claim you have certain rights under the Access to Medical Reports Act 1988: -

- Your consent* is required before 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 to give your 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 your responsibility, as they are not covered by this policy.

Details of the Patients/ Your Usual General Practioner

Patient Name:			
Name of General Practioner:			
Surgery Address:		Post code:	
Telephone number:			
Name of hospital admitted to (if applicable)			
Consultant Name:			

Declaration

I consent to tifgroup 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	

Patient's Details

Title:		First Name:		Last Name:	
Address:					
Post Code:					

Signature of patient or next of kin:		Date:	DD/MM/YYYY
Print Name:			
If next of kin, please advise your relationship:			

Consent

I give my authority for you to communicate with the following people who I may wish to contact you, or to be a point of contact for me, whilst my claim is being finalised.

Full Name:	
Full Name:	

Your Signature:		Date:	DD/MM/YYYY