

Medical Certificate – (Insured Traveller)

This medical certificate is required by Nationwide in respect of a claim made by our insured/your patient under their travel insurance policy (“the Claim”), which links to their medical condition which has resulted in the Claim (“the Condition”).

This medical certificate should be completed by the insured’s medical professional.

Responsibility for any charges incurred in respect of this medical certificate rests with the insured.

For your information:

1. Our Insured’s / Your patient’s name is _____
2. Our Claim Reference Number is _____
3. The insurance policy was taken out on _____
4. The trip was booked on _____
5. The trip was due to start on _____

PLEASE COMPLETE QUESTIONS IN BLOCK CAPITALS, THIS WILL AID UNDERSTANDING.

1. Patient Name:	
<hr/>	
2. Patient’s Date of Birth:	
<hr/>	
3. In what context do you know the patient?:	
<hr/>	
4. What is the Condition that has caused the Claim?:	
<hr/>	
5. On what date did your patient’s symptoms first present in respect of the Condition?:	
<hr/>	
6. On what date did your patient first seek medical advice or help in respect of the Condition? and who did they see if this was not you?:	

7. On what date were you first consulted in respect of your patient's Condition?:

8. On what date was your patient's Condition diagnosed?:

9(a) Has this Condition, or anything directly related to it, been suffered before?:

Yes / No

9(b) If yes, please provide details, and dates of diagnosis:

10: For this question, we only need information if it is **related** to the Condition that caused this Claim (as per Q4), or any other condition(s) directly related to the Claim:

10 (a) As at the date the insurance was taken out with us or the trip was booked, whichever is later, had your patient during the preceding 12 months suffered from, received treatment or is currently receiving treatment or advice for:

A heart or cardiovascular problem (such as heart disease, stroke or angina)?	Yes / No
Diabetes, high blood pressure or high cholesterol?	Yes / No
Any form of cancer?	Yes / No
Any breathing condition (such as asthma or COPD)?	Yes / No
Any gastrointestinal condition (such as Crohn's Disease or IBS)?	Yes / No
Had or been recommended to have treatment or medication prescribed by a doctor, including repeat prescriptions, whether taking it or not?	Yes / No
Received inpatient treatment or been aware of the need for inpatient treatment? (We define inpatient treatment as where a patient admitted and remain in hospital for at least 24 hours.)	Yes / No
Had Investigation of a medical condition or awaiting a diagnosis?	Yes / No

10 (b) If yes to any of these, please clearly provide details and dates of investigation, reasons for referral or treatment, together with details of any diagnosis and medication / treatment prescribed (including dosage):

11(a) As at the date the trip was booked (as shown above), would your patient have been acting contrary to medical advice to have booked travel (or would they have been had such advice been sought):

Yes / No

11(b) If Yes please explain your answer:

12(a) In your medical opinion, was the Condition sufficiently severe to have caused the insured to have cancelled or have cut short their trip:

Yes / No

12(b) Please explain your answer:

If the Claim relates to a pregnancy, please complete these additional questions:

13. On what date was your patient's pregnancy confirmed:

14. What specific reason associated with your patient's pregnancy meant that the trip could not be completed:

Space for additional comments if required	
--	--

Declaration by the medical practitioner: I confirm that the information supplied above is a true and accurate statement of the details relating to my patient and that there is no further material information relating to this matter that I am aware of.	Please endorse this document with your surgery/hospital stamp here:	
Signed:	Name:/job title	Completion Date _____

ACCESS TO MEDICAL REPORTS FORM - TO BE COMPLETED BY PATIENT / ON BEHALF OF PATIENT

Access to medical reports act 1988

As part of your insurance claim a medical report may be required from your Doctor in order to assess the claim's validity. However, before UK Insurance Limited can apply for a medical report your consent is needed. Before signing this consent form at the end of this letter you should read the following summary of your rights:

You can withhold your consent but if you should do so your insurers may be unable to process your claim.

If you wish to see the report, we will tell you at the same time we write to the Doctor and you will then have 21 days to contact the Doctor about arrangements for you 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.

You can ask your 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 amend your comments. Your Doctor can in certain circumstances withhold from you the Report or any part of it.

N.B. For more general information on how your personal information may be processed, please refer to the 'Your information' section of your policy wording.

CONSENT TO OBTAIN A MEDICAL REPORT

I have been informed of my statutory rights under the Access to Medical Reports Act 1988, as explained above and in connection with my insurance claim I hereby consent to the insurers seeking medical information from any Doctor who at anytime has attended me concerning anything which affects my physical or mental health in connection with this claim and I agree that a copy of this consent shall have the validity of the original.

I wish to see the Report before it is sent to the Insurers:

I do not wish to see the Report before it is sent to the Insurers:

Signed

Date

Name (please print)

NAME AND ADDRESS OF DOCTOR

