Medical certificate

(Please ensure this certificate is completed by the GP of the person causing the cancellation)

Details of the patient

Name and address of patient

Age

Date of birth D D M M Y Y Y Y

Are you the patient's usual GP? ☐ Yes ☐ No

How long has the patient been with the practice? Years Months

Precise nature of illness/injury causing the cancellation of the holiday/trip

Are you prepared to certify that it is only due to the condition described above, that the claimant(s) are compelled to cancel? ☐ Yes ☐ No

Is the condition directly or indirectly related to any known pre-existing condition? ☐ Yes ☐ No

If yes, please provide details of the condition

Date illness/injury causing your patient's claim began D D M M Y Y Y Y

Date you were first consulted D D M M Y Y Y Y

Date referred to a consultant (if applicable) D D M M Y Y Y Y

Date wait listed for operation (if applicable) D D M M Y Y Y Y

Date admitted to hospital (if applicable) D D M M Y Y Y Y

Date discharged from hospital (if applicable) D D M M Y Y Y Y

Details of the patient (continued)

Claims due to pregnancy

Date confirmed D D M M Y Y Y Y

Expected due date D D M M Y Y Y Y

The reason why the pregnancy necessitates the cancellation of the holiday/trip

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Date you advised the patient to cancel D D M M Y Y Y Y

If you did not advise the patient to cancel, on what date did the cancellation become medically necessary? D D M M Y Y Y Y

If possible, please state when the patient will be fit to travel D D M M Y Y Y Y

Has a terminal prognosis been made? ☐ Yes ☐ No

If yes, what date was the patient made aware of this? D D M M Y Y Y Y

Please provide details of any previous medical history

Date the holiday/trip was booked D D M M Y Y Y Y

Were you consulted prior to the booking being made? ☐ Yes ☐ No

On the above date, was the patient fit and well? ☐ Yes ☐ No

If no, please provide details

Was the booking contrary to medical advice? ☐ Yes ☐ No

If yes, please provide details

Declaration

I have examined the patient and referred to their medical records and I declare that the information given is correct and that no details relevant to this case have been omitted.

Name

Qualifications

Signature

Date D D M M Y Y Y Y

Please return this form to your Insurance Broker or zpc.claims@uk.zurich.com

Additional information

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