Medical Certificate

Linkham Services
Unit/Office 36, 88-90 Hatton Garden
London, EC1N 8PN

Claim Ref:

This Certificate is to be completed by the Usual Medical Practitioner of the person whose illness/injury has given rise to the claim.

Note - Any charge made for the completion of this certificate is the responsibility of the insured and is not refundable under the Insurance Policy.
- Please answer all questions. Ticks, dashes, N/A etc will not be acceptable.
-This information will be treated as Private and Confidential.
- A Certificate not containing the specific information requested will not normally suffice.

1. Full Name of Patient/Person whose condition has given rise to the claim.
2. Date of Birth.
3. Are you the regular medical attendant? (a) If yes, for how long.
   (b) If no, what is your involvement with this matter.
4. State precise nature of :-
   Medical condition/illness/injury cause of death, that gives rise to the claim.
   If injury, state how this was caused.
5. Has the patient suffered from same or similar condition in the past?
6. (a) State exact date of onset as in 4. (b) Date first consulted. (c) Date of any serious deterioration, if applicable.
7. What ongoing medical conditions (or any medical complication directly attributable to that condition) investigated by a registered medical practitioner did the person above suffer at the date the holiday insurance was purchased? Please give consultation dates.
8. For what medical conditions of the person above was there prescribed medication or treatment for other than a minor ailment by a registered medical practitioner during 30 days (or 90 days for a person 70 years of age or over) immediately preceding the date the holiday insurance was purchased? Please give consultation dates.
9. Is the illness/injury attributable to HIV or HIV related illness, including AIDS?
10. Has the person named in 1 above received a terminal prognosis? If yes, what date was this given to:
    (a) the person named in 1 above. (b) the claimant, if not the same person.
11. Was the person above receiving or on a waiting list for, or recovering from in-patient treatment in a hospital or nursing home at the date the Insurance was purchased? Please give consultation dates.
12. Please state: (a) whether the patient consulted you prior to their journey as to the advisability of undertaking the holiday or journey. If so, on what date
    (b) whether, in your opinion the patient was fit to travel at the time of departure.
13. Please provide details of patients state of health at the time the Insurance was purchased.
14. If claim is a result of pregnancy, please advise :- (a) Date pregnancy confirmed. (b) LMP. (c) ECD.
15. If cancellation state exact reason for the cancellation.
16. Please advise the date when it first became apparent that the holiday should be cancelled.
17. Please state the exact date you advised the need to cancel.
18. Are you prepared to certify that, solely due to the condition described in 4 above, the claimants are compelled to cancel the holiday arrangements?

To be completed by the Usual Medical Practitioner

I have examined the patient and/or referred to his/her medical records and I declare that the information given is correct and that no details relevant to the case have been omitted.

Name (Please print)..... Qualifications.....

Address .....

Surgery Stamp.

Signature ..... Date.....