Hollard Travel Insurance: Travel Claims Medical Certificate

Complete this form if your claim is due to an accident, sickness, disability or death.

The form must be completed in regard to the patient (injured, ill or disabled person) whose sickness or injury resulted in this claim or Executor of the Estate in the event of a death.

This medical certificate is to be completed:

- at the claimant's expense
- by the patient's usual Doctor or Dentist in Australia
- for all cases of medical, dental, unexpected expense and cancellation claims resulting from an accident, sickness, disability or death.

The medical practitioner is respectfully requested to give as much detail as possible in order for us to assist our insured and avoid the necessity of additional enquiries

Claim Number:

Claimants Name:

1. Patient's Name: Patient's Date of Birth: / /

2. Are you the Patient's usual GP? ☐ Yes ☐ No

2A. If yes, how many years/months?

2B. If no, please give details of the Patient's usual GP:

3. What is the precise diagnosis of the injury or sickness that led to this claim?

4. Date of onset of injury or sickness:

5. Date you were first consulted for this injury or sickness:

5A. What test(s) did you prescribe?

5B. Date test(s) prescribed:

5C. Date test(s) performed:

5D. Date results advised to Patient:

6. Was the Patient under the care of any other Doctors, including Specialists? ☐ Yes ☐ No

6A. If yes, please provide the details of the other treating Doctors:

6B. Date first referred to a Specialist:

6C. Name of Specialist/Surgeon:

6D. Phone number of Specialist/Surgeon:

6E. Email of Specialist/Surgeon:

6F. Postal address of Specialist/Surgeon:

7. Have you previously treated or advised this patient in respect of the same sickness or injury as described in question 3?

7A. If yes, please provide details below:

7B. If yes to '7' was this sickness/injury the same or a similar/related injury? ☐ Yes ☐ No

7C. If yes to '7', please state when you last treated the patient, prior to the occurrence giving rise to this claim, and give details of the treatment and/or medication prescribed:

7D. If yes, was the patient advised to continue this treatment and/or medication:

Until departure on the Journey ☐ Yes ☐ No

Whilst on the Journey? ☐ Yes ☐ No

8. Did the Patient travel against your advice? ☐ Yes ☐ No

9. Are you prepared to certify that the Claimant(s) were required to cancel their travel arrangements solely due to the condition described in question 3? ☐ Yes ☐ No

10. Please attach your consultation notes relevant to this condition described in question 3

☐ I certify that the Statements contained in this medical certificate are true and correct.

Doctor's Name:

Doctor's Signature: Date: / /

Qualification:

Phone: Fax:

Email:

Address:

Suburb: State: Postcode:

Please return completed form to Hollard Travel Insurance Claims

Email Address travelclaims@hollard.com.au
Phone Number +61 2 8883 7801
Postal Address Hollard Travel Insurance Claims
Locked Bag 2010
St Leonards NSW 1590

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