

Medical Certificate: Personal Accident or Sickness

GlobeCover Personal Accident & Travel Insurance

To the claimant: Please ask the patient's doctor to complete this form. The Medical Certificate is to be completed at your own expense.

To the patient's parents or legal guardian if the patient is under 18 years of age: Please ask the patient's doctor to complete this form. The Medical Certificate is to be completed at your own expense.

To the patient's doctor or medical practitioner: please complete this form and return it to the claimant or if the patient is under 18 years of age, to the patient's parents or legal guardians or return to the address below.

PART 1 - PERSONAL DETAILS

Name of patient

Are you the patient's usual medical attendant? Yes No

Professional status GP Physiotherapist Other (please state)
Nurse Consultant

Are you still in attendance? Yes No

Date you first saw / treated the patient

How long has the patient been under your care?

Accident details (if applicable)

Date of the accident

Description of the accident

Describe injuries *(If a hand, arm, foot or leg please state right or left)*

Treatment and prognosis

Sickness details (if applicable)

Full details of sickness

When did the symptoms first appear?

Has the patient had this sickness before? Yes No

If 'yes', when?

Diagnosis

Treatment and prognosis

Details of the loss

Could anything in the patient's medical history have contributed to the occurrence of the accident or sickness, or affect the patient's recovery?

Yes No

If 'yes', please provide details

Have any of the conditions referred to above left any effect upon the patient's general health?

Yes No

If 'yes', has the patient knowledge of the nature of the conditions?

Yes No

For what period has the patient been totally unable to attend to any of their normal duties?

From

To

If patient is still totally disabled, please state probable date of partial resumption to their normal duties

If patient is partially disabled, state from when and probable date of complete recovery

From

To

If patient has recovered what was the date of recovery?

If the patient was hospitalised, please advise dates

From

To

PART 2 - DECLARATION

I certify that these particulars are true and correct

Name

Signed

Date

Qualifications

Address

Surgery stamp

Any fee payable for completion of this certificate is the responsibility of the claimant and not AIG Europe Limited.

THE ISSUE OF THIS FORM DOES NOT CONSTITUTE AN ADMISSION OF LIABILITY UNDER THE POLICY.

To help us process your claim quickly, please make sure all sections are completed in full and all requested documents are scanned and emailed or posted to us.

Email Globecoverclaims.ie@aig.com

Post [GlobeCover Claims, 30 North Wall Quay, International Financial Services Centre, Dublin 1, Ireland](#)

Telephone +353 (0)1 208 1400

Fax +353 (0)1 283 7773

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