Tokio Marine & Nichido Fire Insurance Co., Ltd.
ABN 80 000 438 291

Managing Agent in Australia:
Tokio Marine Management (Australasia) Pty. Ltd.
ABN 69 001 488 455

RAC Travel Insurance Claims, C/- TMNFA
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Tel. 1300 209 352

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MEDICAL CERTIFICATE

To be completed by the person whose illness/injury caused the claim.
Medical Authority: With regards to medical expenses/cancellation/additional expenditure claims, I authorise any hospital, physician or other person who has attended me, to give ..... or its representative, any, or all information, with respect to any sickness or injury, medical history, consultation, prescription, or treatment, and copies of all hospital or medical records. I agree that a photostat copy of this authorisation will be considered as effective and valid as the original.

Name	**Date of Birth**	**Signature**
.....	.....	.....

Claimant Name _____ **Claim No/ Policy No** _____

Are you the patient's regular GP ? **Y/N** If yes, for how long? _____

If this claim relates to pregnancy please complete the following –

Date pregnancy was confirmed How many weeks pregnant was patient as at ...../...../.....

_____ _____

Please provide a precise diagnosis of the medical condition/illness/injury/cause of death that relates to this claim. If this is an injury, please also state the cause of this injury.

_____

Date of the initial onset of this illness/injury. _____

Date on which you were first consulted for this illness/injury. _____

Has your patient previously been investigated, diagnosed or treated for the same/similar/related conditions. Please provide details.

Did you refer your patient to a specialist? If yes, please provide date of referral & specialist contact details.

On what date was there a deterioration/exacerbation of this medical condition/injury?

Did you recommend that travel be cancelled or postponed due to the patient's state of health? **Y/N**

On what date did you make this recommendation?

To be completed by the usual Registered General Practitioner (GP)

I certify that I have examined the patient named above and/or have referred to their medical records and declare that the information given is true and correct and that no details relevant to the claim have been omitted.

Signature

Name

Qualifications

Date

Surgery Stamp