

**Postal Address:**  
Suresave Claims  
PO Box 162  
Toowong QLD 4066

## TRAVEL INSURANCE CLAIM FORM

This travel insurance is arranged and managed by ETI Australia Pty Ltd, trading as Mondial Assistance (Mondial Assistance) ABN 52 097 227 177, AFSL 245631 and is underwritten by Allianz Australia Insurance Limited (Allianz) ABN 15 000 122 850, AFSL 234708. Mondial Assistance is authorised by Allianz to enter into and arrange the policy and deal with and settle any claims under it, as an agent of Allianz, not as your agent.

Email: [travelclaims@mondial-assistance.com.au](mailto:travelclaims@mondial-assistance.com.au)

Phone: 1300 656 468

Facsimile: (07) 3305 7016

Claim No: \_\_\_\_\_

Date Received: \_\_\_\_\_

*(Office Use Only)*

### Privacy

The Privacy Act 1988 requires us to tell you that Mondial Assistance as agent for Allianz collect your personal information in order to handle your claim. We may have to disclose your personal information to third parties such as other insurers, travel agents, medical practitioners, intermediaries, loss adjusters, external claims data collectors, investigators and the Insurance Reference Services (IRS), or as required by law. You have the right to seek access to your personal information at any time. Please contact Mondial Assistance on 1800 023 737 for access.

### Internal Dispute Resolution

Disputes are not an everyday occurrence, however, Mondial Assistance provides an internal dispute resolution process should any dispute arise. Please feel free to ask for details. If you are not satisfied with the outcome of this process, we will advise you how to contact the insurance industry's external independent complaints scheme.

### Fraud

Insurance fraud places additional costs on honest policyholders. Fraudulent claims force insurance premiums to rise. We encourage the community to assist in the prevention of insurance fraud. You can help by reporting insurance fraud. All information will be treated as confidential and protected to the full extent under law. Report insurance fraud by calling 1800 453 937.

## STEP 1 – CLAIM FORM COMPLETION REQUIREMENTS

- Please read this claim form carefully and complete ALL steps outlined on this form.
- Please use block letters.
- Please retain a copy of ALL documents for your records.
- Documents in a foreign language are required to be translated into English at your own expense.
- The claim form and ALL supporting documentation may be mailed, emailed or faxed to us. **Please note: We reserve the right to request the original receipts, reports or any other documentation be submitted in order to substantiate the claim.**
- Please refer to the specified documentation requirements that you will need to provide when lodging your claim. As each claim is unique, further information may be requested by us.
- **We cannot process your claim if you do not supply the listed documentation with your fully completed and signed claim form.**
- **A copy of your Certificate of Insurance must be supplied with your claim.**
- **If any part of your claim is of a dishonest or fraudulent nature, then your claim will be denied and will be referred to the appropriate authorities.**

## STEP 2 – CLIENT DETAILS

### A. Client Details

|   |  |   |  |
|---|--|---|--|
| 1. Travel Insurance Policy Number: _____  |  |   |  |
| 2. Surname of policy holder/s (as shown on the Certificate of Insurance): _____ |  |   |  |
| Surname of policy holder/s: _____   |  |   | <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms |
| Surname of policy holder/s: _____   |  |   | <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms |
| 3. Given Name/s: _____  |  | 4. Date of Birth: _____                 |  |
| Given Name/s: _____   |  | Date of Birth: _____                    |  |
| 5. Home Address: _____  |  |   |  |
|   |  |   | Postcode: _____  |
| 6. Postal Address (if different to home address): _____                         |  |   |  |
|   |  |   | Postcode: _____  |
| 7. Telephone Numbers: Home: ( ) _____   |  | Mobile: _____                           |  |
|   |  | Work: ( ) _____                         |  |
| 8. Email Address: _____   |  | 9. Occupation: _____                    |  |
| 10. Travel Agency responsible for booking arrangements: _____                   |  |   |  |
| 11. Address and phone number of Travel Agency: _____                            |  |   |  |
| 12. Travel Consultants Name: _____  |  | 13. Date of booking arrangements: _____ |  |
| 14. Date of Insurance payment: _____  |  | 15. Travel Destination: _____           |  |
| 16. Date of Departure: _____  |  | 17. Date of Return: _____               |  |

**If you wish to give authority for another person to act on your behalf in respect to this claim you must complete the following details (otherwise we will not be able to give any information about your claim to any other person).**

I/We, hereby authorise (Name): \_\_\_\_\_  
of (Address): \_\_\_\_\_ Postcode: \_\_\_\_\_  
Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

to act on our behalf in respect to this claim and to be provided with information relating to the claim.

## B. Insurance Arrangements

1. Did you pay for your travel arrangements using a credit card?  Yes  No

If Yes, please complete the following:

Credit Card Provider (e.g. Commonwealth Bank) \_\_\_\_\_

Card Type (e.g. Visa; MasterCard; credit card) \_\_\_\_\_

2. Do you have a Travel Insurance Benefit Cover under your credit card?  Yes  No

If Yes, have you made a claim against this?  Yes  No

3. Do you have private health insurance?  Yes  No

If Yes, please complete the following:

Name of Fund: \_\_\_\_\_ Membership Number: \_\_\_\_\_

Have you made a claim under this policy?  Yes  No

**(If Yes, include evidence of the amount received from the fund)**

4. Do you have Personal Effects Cover included in your home contents insurance?  Yes  No

If Yes, please complete the following:

Name of the Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Have you lodged a claim for this loss under this policy?  Yes  No

## C. GST Purposes (Only applies if your policy was purchased for a business)

**Note:** If you are entitled to an Input Tax Credit (ITC) for the GST on your policy, you need to advise us of this entitlement to ensure GST/ITC is dealt with appropriately in separate settlement proceeds.

If you are a business and registered for GST and do not provide us with your ABN, we may have to withhold tax on payments we make under your claim.

1. The ITC on my premium is \_\_\_\_\_ %

2. My ABN is: \_\_\_\_\_

## D. Previous Travel Claims History

1. Have you made previous travel insurance claims?  Yes  No If Yes, please answer questions 2 to 7. If No, please go to Step 3 (next page)

2. Date(s): \_\_\_\_\_

3. Name of Insurance Company claimed from: \_\_\_\_\_

4. Claim Number: \_\_\_\_\_

5. Amount claimed: \_\_\_\_\_

6. Amount paid: \_\_\_\_\_

7. Please provide full details of the event that led to the claim: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## STEP 3 – CLAIM INFORMATION

In this Section we will ask you the circumstances of your claim and the amount that you are claiming.  
Please tick the applicable box(s) relating to your claim and answer the corresponding Section.

- A.** Overseas Medical and Dental Expenses Claim – please go to page 3
- B.** Cancellation Claim (Cancellation of Pre-paid Arrangements) – please go to page 4
- C.** Additional Expenses Claim (Additional Travel or Accommodation Expenses) – please go to page 4
- D.** Luggage and Personal Effects Claim – please go to page 5
- E.** Rental Vehicle Excess Claim – please go to page 5
- F.** Delayed Luggage Allowance Claim – please go to page 6
- G.** Other – please go to page 6

**Please answer all questions relating to what is being claimed, otherwise we will be unable to process your claim.**

### A. Overseas Medical and Dental Expenses Claim

1. Name of the person who incurred illness/injury: \_\_\_\_\_
2. The patient's relationship to the policy holder: \_\_\_\_\_
3. Nature of the illness/injury: \_\_\_\_\_  
\_\_\_\_\_
4. Did the illness/injury occur whilst the ill/injured person was working?  Yes  No  
If Yes, please provide name, address and phone number of ill/injured person's employer: \_\_\_\_\_
5. How did the illness/injury occur? \_\_\_\_\_  
\_\_\_\_\_
6. Date first occurred: \_\_\_\_\_
7. Did you contact our 24 hour Assistance Service?  Yes  No If Yes, date: \_\_\_\_\_
8. Has the ill/injured person suffered from the same or similar illness/injury before?  Yes  No  
If Yes, please provide details including dates: \_\_\_\_\_
9. Name, address and phone number of ill/injured person's usual Doctor/Dentist: \_\_\_\_\_  
\_\_\_\_\_
10. Name, address and phone number of Doctor/Dentist who treated the illness/injury whilst abroad: \_\_\_\_\_  
\_\_\_\_\_
11. Country where illness was treated: \_\_\_\_\_
12. If admitted to hospital: Date admitted: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm  
Date discharged: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm

13. Please list each receipt/bill separately in the table below:

| Name of Doctor/Dentist/<br>Pharmacy/Hospital or Provider | Treatment<br>Performed | Date of<br>Treatment | Amount Charged<br>(State Currency) | Paid<br>Yes / No | Refund from<br>Health Funds |
|--|------------------------|----------------------|------------------------------------|------------------|-----------------------------|
| e.g. Doctor R Smith                                      | e.g. Consultation      | e.g. 10/02/05        | e.g. EUR 100                       | e.g. Yes         | e.g. EUR 75                 |
|  |                        |                      |                                    |                  |                             |
|  |                        |                      |                                    |                  |                             |
|  |                        |                      |                                    |                  |                             |
|  |                        |                      |                                    |                  |                             |
|  |                        |                      |                                    |                  |                             |

Claims will be converted to Australian dollars using the currency rate applicable at the date and time the expenses were incurred.

**PLEASE PROVIDE US WITH ALL OF THE FOLLOWING REQUIRED DOCUMENTATION RELATING TO YOUR CLAIM:**

- A copy of your Certificate of Insurance must be supplied with your claim.
- The itemised account/s giving a breakdown and description of the costs claimed.
- The medical report/dental report/hospital records giving full details of the matter for which treatment was sought.
- **PLEASE PROVIDE US WITH A COMPLETED MEDICAL CERTIFICATE (SEE PAGE 7).**  
**EXCEPT IN THE CASE OF A MINOR ILLNESS OR INJURY YOUR CLAIM CANNOT BE PROCESSED WITHOUT A COMPLETED MEDICAL CERTIFICATE.**

## B. Cancellation Claim

1. Date of travel cancellation/change: \_\_\_\_\_
2. Date of the incident that caused you to cancel your trip: \_\_\_\_\_
3. Was your travel cancelled/changed for a medical reason?  Yes  No If Yes, please answer questions from 4 to 8. If No, please answer questions 7 to 9.
4. Name of person who incurred the illness/injury: \_\_\_\_\_
5. Nature of the illness/injury: \_\_\_\_\_
6. Has the ill/injured person suffered from the same or similar illness/injury before?  Yes  No
7. Date your trip was originally booked: \_\_\_\_\_
8. Date your trip was cancelled: \_\_\_\_\_
9. Please provide details of the reason why you cancelled your trip:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

10. Please list each receipt/bill separately in the table below:

| Cost of Original Item Booked | Description of Booked Item | Name of Carrier/Travel Company | Date of Intended Use | Date of Cancellation | Amount of Refund Received | Taxes Charged on Cancelled Trip | Amount Being Claimed |
|------------------------------|----------------------------|--------------------------------|----------------------|----------------------|---------------------------|---------------------------------|----------------------|
| e.g. AUD \$1500              | e.g. London Flight QF1     | e.g. Qantas                    | e.g. 10/02/05        | e.g. 30/01/05        | e.g. AUD \$500            | e.g. AUD \$20                   | e.g. AUD \$1000      |
|                              |                            |                                |                      |                      |                           |                                 |                      |
|                              |                            |                                |                      |                      |                           |                                 |                      |
|                              |                            |                                |                      |                      |                           |                                 |                      |
|                              |                            |                                |                      |                      |                           |                                 |                      |
|                              |                            |                                |                      |                      |                           |                                 |                      |
|                              |                            |                                |                      |                      |                           |                                 |                      |

Claims will be converted to Australian dollars using the currency rate applicable at the date and time the expenses were incurred.

### PLEASE PROVIDE US WITH ALL OF THE FOLLOWING REQUIRED DOCUMENTATION RELATING TO YOUR CLAIM:

- A copy of your Certificate of Insurance must be supplied with your claim.
- The travel agent's letter detailing all cancellation charges AND the Cancellation or Amendment Form at page 8 of this claim form, fully completed by your travel agent. This **MUST** show all amounts paid for your travel and amounts refunded.
- Any relevant documentation that which supports your reason for cancelling.
- If your travel was cancelled due to medical reasons, the Medical Certificate on page 7 **MUST** be completed by the Doctor/Dentist who recommended cancellation. Option 2 on the Medical Certificate needs to be completed.
- If your travel was cancelled due to the unfortunate event of a death, a copy of the Death Certificate will be required.

## C. Additional Expenses Claim

1. Please state the reason/event that caused the additional expenses being incurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. What was the unexpected cost incurred?

Please list each receipt/bill separately in the table below:

| Date of Expense | Description of Cost | Cost         | Date of Original Plan | Description of Original Cost | Cost        |
|-----------------|---------------------|--------------|-----------------------|------------------------------|-------------|
| e.g. 24/07/06   | e.g. Hotel in Paris | e.g. EUR 100 | e.g. 24/07/06         | e.g. Flight to Munich        | e.g. EUR 75 |
|                 |                     |              |                       |                              |             |
|                 |                     |              |                       |                              |             |
|                 |                     |              |                       |                              |             |
|                 |                     |              |                       |                              |             |
|                 |                     |              |                       |                              |             |
|                 |                     |              |                       |                              |             |

Claims will be converted to Australian dollars using the currency rate applicable at the date and time the expenses were incurred.

### PLEASE PROVIDE US WITH ALL OF THE FOLLOWING REQUIRED DOCUMENTATION RELATING TO YOUR CLAIM:

- A copy of your Certificate of Insurance must be supplied with your claim.
- The travel agent's letter detailing all cancellation charges AND the Cancellation or Amendment Form at page 8 of this claim form, fully completed by your travel agent. This **MUST** show all amounts paid for your travel and amounts refunded.
- A copy of your itinerary showing the details of your travel arrangements.
- The copy of all receipts, credit card vouchers or statements for any amounts you want us to pay for.
- If the Additional Costs were incurred because of a transport provider, please attach a letter from them confirming the reason why.
- If the Additional Costs were incurred due to an illness, Option 3 on the Medical Certificate on page 7 must be completed by the Doctor/Dentist of the person whose state of health or death caused this claim (be this the insured or any other party).
- If your travel was cancelled due to the unfortunate event of a death, a copy of the Death Certificate will be required.

## D. Luggage and Personal Effects Claim

1. Date of Incident: \_\_\_\_\_ 2. Time: \_\_\_\_\_ am/pm
3. Location: \_\_\_\_\_ 4. Country: \_\_\_\_\_
5. Please state in full exactly what occurred (please attach a letter if insufficient space):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

6. Did you report the event to the police?  Yes  No

If Yes, when and where: \_\_\_\_\_

7. Were the goods stolen from your vehicle?  Yes  No

If Yes, were the goods under your control when they were stolen or damaged?  Yes  No

8. Have you claimed the loss under your household contents insurance?  Yes  No

9. Have you replaced any of the items which were stolen or damaged?  Yes  No

If Yes, please provide proof of purchase. \_\_\_\_\_

10. Please complete the below schedule in full:

| Full Description of Article          | Original Purchase Price (State Currency) | Date of Original Purchase | Place of Purchase | Amount Claimed | Proof of Ownership attached? Yes / No |
|--------------------------------------|--|---------------------------|-------------------|----------------|---------------------------------------|
| e.g. Silver 1998 Seiko Digital Watch | e.g. EUR 100                             | e.g. 24/07/06             | e.g. Paris        | e.g. EUR 75    | e.g. Yes (receipt attached)           |
|                                      |  |                           |                   |                |                                       |
|                                      |  |                           |                   |                |                                       |
|                                      |  |                           |                   |                |                                       |

Claims will be converted to Australian dollars using the currency rate applicable at the date and time the expenses were incurred.

### YOUR CLAIM WILL NOT BE PAID WITHOUT PROOF OF OWNERSHIP.

#### PLEASE PROVIDE US WITH ALL OF THE FOLLOWING REQUIRED DOCUMENTATION RELATING TO YOUR CLAIM:

- A copy of your Certificate of Insurance must be supplied with your claim.
- Proof of Ownership – This may be in the form of receipts, warranties, invoices, statements, guarantees, valuations, credit card statements, boxes or accessories.
- A Police Report (if the claim is theft related).
- In the case of damaged items – please send us a quotation for repairs and the damaged items.
- A loss report from the authority you reported the loss to: e.g. Police Report, Letter from Hotel, or a Property Irregularity Report (PIR) from the Carrier.
- If applicable, a letter from the carrier outlining their compensation paid to you.
- Your airline tickets and baggage tags.

## E. Rental Vehicle Excess Claim

1. Date and time of incident: \_\_\_\_\_ 2. Location of incident: \_\_\_\_\_
3. Rental car company name: \_\_\_\_\_ 4. Country where the vehicle was rented: \_\_\_\_\_
5. Please state in full, exactly what happened for the claim to arise (if necessary, a diagram may be used to depict the event):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

6. Was the damage due to a collision with another vehicle?  Yes  No

If Yes, please provide the name and address of the person who was driving the other vehicle involved in the collision:  
 \_\_\_\_\_  
 \_\_\_\_\_

Please provide the registration number of the other vehicle: \_\_\_\_\_

7. Please provide the name and address of the other drivers' Insurance Company:  
 \_\_\_\_\_  
 \_\_\_\_\_

8. Did police attend the incident?  Yes  No

9. Was the accident your fault?  Yes  No

10. Repair costs: \_\_\_\_\_ 11. Date the damage was paid for: \_\_\_\_\_

12. Excess you were liable to pay: \_\_\_\_\_ 13. Amount you are claiming for: \_\_\_\_\_

14. Have you received compensation from any person or party involved in the accident or incident:  Yes  No

If Yes, please state the amount received: \_\_\_\_\_

#### PLEASE PROVIDE US WITH ALL OF THE FOLLOWING REQUIRED DOCUMENTATION RELATING TO YOUR CLAIM:

- A copy of your Certificate of Insurance must be supplied with your claim.
- A copy of the hire agreement, the credit card voucher for the payment of the excess and a copy of the repair account/quote.
- A copy of the police report if the vehicle was involved in an accident.
- Rental company incident report.

## F. Delayed Luggage Allowance Claim

- Name of carrier who delayed your luggage: \_\_\_\_\_
- Arrival date: \_\_\_\_\_ 3. Arrival time: \_\_\_\_\_ am/pm
- Date that your luggage was returned to you: \_\_\_\_\_ Time of return: \_\_\_\_\_ am/pm
- What compensation was received from the carrier? \_\_\_\_\_
- Please complete the below schedule in full:

| Description of Personal Effect Purchased | Date of Purchase | Price Paid   | Store from where Item was purchased | Receipt attached Yes / No   |
|--|------------------|--------------|-------------------------------------|-----------------------------|
| e.g. Woollen Jumper                      | e.g. 10/02/05    | e.g. EUR 100 | e.g. Benetton of London             | e.g. Yes (receipt attached) |
|  |                  |              |                                     |                             |
|  |                  |              |                                     |                             |
|  |                  |              |                                     |                             |
|  |                  |              |                                     |                             |
|  |                  |              |                                     |                             |

Claims will be converted to Australian dollars using the currency rate applicable at the date and time the expenses were incurred.

### PLEASE PROVIDE US WITH ALL OF THE FOLLOWING REQUIRED DOCUMENTATION RELATING TO YOUR CLAIM:

- A copy of your Certificate of Insurance must be supplied with your claim.
- A loss report issued by the carrier (usually in the form of a Property Irregularity Report (PIR)).
- Confirmation of the date and time the delayed luggage was delivered.
- The receipts, credit card vouchers or statements showing the monetary amount of the essential item purchased.
- Your airline tickets and baggage tags.

## G. Other

- Please tell us in as much detail as possible what happened to you in order for you to make this claim. Be as specific as possible, including dates and amounts paid. If there is not enough room in the space provided, you may continue your description of the events on a separate piece of paper.  
\_\_\_\_\_  
\_\_\_\_\_

- Which Policy Benefit Section(s) do you believe is the most applicable Section under which you can make this claim?  
\_\_\_\_\_

### PLEASE PROVIDE US WITH ALL OF THE FOLLOWING REQUIRED DOCUMENTATION RELATING TO YOUR CLAIM:

- A copy of your Certificate of Insurance must be supplied with your claim.
- Please provide ALL relevant documentation relevant to the application of this claim.
- To process your claim more efficiently, please provide us with as much information as possible.

## STEP 4 – PAYMENT DETAILS AND DECLARATION

- For faster payment, provide your bank details for a direct credit to your nominated bank account. We cannot deposit into a credit card account.**

Note that for an unpaid account the payment will be issued to the provider. In such event, **we cannot make payment to the provider until we receive payment of any excess payable from you.**

Name of Bank: \_\_\_\_\_

Branch: \_\_\_\_\_

Account Holder: \_\_\_\_\_

BSB Number:    –    Account Number:

- By cheque** to your postal address: \_\_\_\_\_

Postcode: \_\_\_\_\_

## CLAIM SUBMISSION CERTIFICATION

I/We certify that this claim form has been completed in full and all required information and documentation as specified on this claim form is attached to this signed claim form.

I/We certify that the information given in this form is truthful, accurate and complete. No information that is likely to affect this claim has been withheld.

I/We understand that this claim may be refused if information is untrue, inaccurate or concealed.

I/We understand that if this claim is fraudulent, it will be reported to the relevant authorities.

I/We consent to the collection, use and disclosure of personal information in order to handle my/our claim.

I/We acknowledge that if I/we do not agree to the collection of this personal information then Mondial Assistance will be unable to process my/our claim.

I/We acknowledge that I/we will provide all necessary assistance as required by Mondial Assistance to process this claim.

Name (PLEASE PRINT): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**MEDICAL CERTIFICATE**

To be completed by the claimant's usual Doctor/Dentist (at the claimant's expense) in all cases of cancellation and medical claims resulting from accident, illness or death.

Name of person to whom this certificate applies (i.e. the person whose state of health caused the claim): \_\_\_\_\_

\_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Instructions to the Medical Professional:**

Please complete this form in block letters, and provide as much information as possible, as this will accelerate this Travel Insurance claim.

1. **(a)** Are you the patient's usual medical attendant? \_\_\_\_\_

**(b)** If not, do you have access to their medical records? \_\_\_\_\_

The claimant must indicate (by tick box) which is applicable, question 2 or 3.

**2. Alteration to/cancellation of travel arrangements prior to travel.**

**(a)** Did you recommend that travel be cancelled or postponed due to the patient's state of health? \_\_\_\_\_

**(b)** Please give precise details of the nature of the illness or injury which gave rise to this recommendation (including the final diagnosis): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(c)** On what date did you make this recommendation?        /        /

**(d)** On what date did the patient first become aware of their symptoms?        /        /

**(e)** On what date were you first made aware of the condition, or change in the condition?        /        /

**(f)** Has the patient previously been investigated, diagnosed or treated in respect of the same/similar/related illness or injury? \_\_\_\_\_

**(g)** If Yes, please provide details from the patient's history (e.g. dates of incidents, advice, treatment and/or medication): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(h)** Did the patient make the travel arrangements against your advice (or the advice of another medical professional)? \_\_\_\_\_

**OR**

**3. Treatment costs/ additional expenses incurred during travel.**

**(a)** What do you understand to be the illness or injury which resulted in the need to seek medical care/ interrupt the patient's travel plans? \_\_\_\_\_

**(b)** Has the patient previously been investigated, diagnosed or treated in respect of the same/similar/related illness or injury? \_\_\_\_\_

**(c)** If Yes, please provide details from the patient's history (e.g. dates of incidents, advice, treatment and/or medication): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(d)** Was there any indication that medical care may be required on the journey? \_\_\_\_\_

**(e)** Was the patient non-compliant with medical advice whilst on the journey? \_\_\_\_\_

**(f)** Did the patient travel against your advice (or the advice of another medical professional)? \_\_\_\_\_

I certify that the statements contained in this Medical Certificate are true and correct.

Doctor's Signature: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Stamp:

