Cover•More TRAVEL INSURANCE

Submit your claim to Cover-More by: Post Cover-More Claims Department, PO Box 105-203 Auckland 1143
Email claimsprocessing@covermore.co.nz

Medical Authority (To be completed by the person who was ill/injured)

To be completed by the person whose state of health caused the claim (or their Parent/Guardian, Executor of the Estate or Power of Attorney if applicable). Details of the patient's usual doctor (of at least 12 months prior to the policy issue date).

I authorise the insurer or its representatives to obtain from any person or organisation any information in respect of treatment for the medical/dental condition/s/injury/ies or death which resulted in this claim. I acknowledge that a photocopy/scanned copy of this authorisation shall be considered as valid as the original.

Signature of patient/Executor/Power of Attorney

Patient's name

Date of birth __ __ / __ __ / __ __

Signed date __ __ / __ __ / __ __

Name of usual doctor or dentist in New Zealand

Relationship to patient (if applicable)

Doctor's or dentist's phone number

Doctor's or dentist's email address (preferred contact method)

Doctor's or dentist's postal address or fax number (only to be provided if email address is unavailable)

Medical Certificate (To be completed by the patient's usual doctor in New Zealand)

To be obtained at the claimant's own expense from the patient's usual medical practitioner (whom they have been attending for at least 12 months prior to the issue date of the policy). Required for all claims arising from a person's health/medical condition, death or dental condition. If you do not have a usual medical practitioner, please contact us.

IMPORTANT: The medical practitioner is respectfully requested to give as much detail as possible when answering these questions in order to assist our client with their claim and avoid the necessity of additional questions. PLEASE USE BLOCK LETTERS. You may reply in letter format however answers to each of the questions below that are relevant to your patient or the claim being made by the claimant will need to be included.

PLEASE INCLUDE ALL PATIENT DISCHARGE SUMMARIES

1. Name of patient

2. Date of birth __ __ / __ __ / __ __

3. Are you the patient's usual G.P.? ☐ Yes ☐ No

a. If Yes, for how long?

b. If No, do you have access to their medical records? ☐ Yes ☐ No
From what date? __ __ / __ __ / __ __

4. Please give a precise diagnosis of the illness or injury or cause of death that has given rise to the claim. If an injury, how was it sustained?

5. On what date did the patient first consult You in relation to this condition or symptoms of this condition? __ __ / __ __ / __ __

6. Have you or anyone else known to you previously treated or advised this patient in respect of the same/similar/related illness or injury as described in the answer to question 4? ☐ Yes ☐ No

7. Prior to the policy issue date, was the patient receiving any regular advice, treatment or medication or being investigated for this condition or any similar/related condition? ☐ Yes ☐ No If Yes, please give details and please provide details and include copies of all letters from referred specialists, the patient's full medical history, current medications and all hospital visits for the past 2 years.

8. Did you advise the patient to take medication for this condition until the journey commenced? ☐ Yes ☐ No

9. Did you advise the patient to take medication for this condition whilst on the journey? ☐ Yes ☐ No

10. Was there any indication prior to travel that medical care might be required on the journey? ☐ Yes ☐ No

11. Please provide details of the patient's health at the time when the insurance was issued and the likelihood of the patient's health leading to hospitalisation or death after this time.

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12. Please provide the following dates, where applicable.

a. Date of onset of illness/injury/death and/or date of deterioration/exacerbation

__ __ / __ __ / __ __

b. Date tests prescribed

__ __ / __ __ / __ __

c. Date tests carried out

__ __ / __ __ / __ __

d. Date results advised to the patient

__ __ / __ __ / __ __

e. Date referred to specialist/surgeon

__ __ / __ __ / __ __

f. Date of death

__ __ / __ __ / __ __

g. Name and address of specialist/surgeon

13. Date the patient was advised that they would not be able to travel.

__ __ / __ __ / __ __

14. If due to pregnancy:

a. On what date was the pregnancy confirmed?

__ __ / __ __ / __ __

b. How many weeks pregnant was the person on this date?

c. Was the conception medically assisted? ☐ Yes ☐ No

d. Have there been previous complications with this or any other pregnancy? ☐ Yes ☐ No

15. Was the patient on a waiting list for hospital? ☐ Yes ☐ No If Yes, please give details.

16. Was the patient hospitalised?

☐ Yes ☐ No

If Yes, please provide admission date __ __ / __ __ / __ __

I certify that I have examined the patient named above and/or have referred to their medical records and confirm that the information given in this Medical Certificate is a true and correct statement.

Doctor's signature

Name

Date __ __ / __ __ / __ __

Qualification

Telephone

Email address, fax number or postal address

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