Medical Certificate — Personal Accident or Sickness

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.

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? DD / MM / YYYY

How long has the patient been under your care?

Accident details (if applicable):

Date of accident DD / MM / YYYY

Description of accident

Description of 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 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? DD / MM / YYYY to DD / MM / YYYY

If the patient is still totally disabled, please state probable date of partial resumption to their normal duties: DD / MM / YYYY

If patient is partially disabled, state from when and probable date of complete recovery: to DD / MM / YYYY

If patient has recovered what was the date of recovery?

If the patient was hospitalised, please advise dates: to DD / MM / YYYY

Declaration:

I certify that these particulars are true and correct.

Name	
Signature	
Date	DD / MM / YYYY
Qualifications	
Address	
Surgery stamp	

Any fee payable for completion of this certificate is the responsibility of the claimant and not American International Group UK 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.

claimsuk@aig.com
AIG Claims Department, A&H Claims, PO Box 3465, Croydon, CR90 9AG
Telephone: +44 345 602 9429

SUBMIT FORM