Medical Certificate

Underwritten by XL Insurance Company SE

ALC GLOBAL HEALTH INSURANCE

To be completed by the Medical Practitioner or Treating Doctor

In order for Global Response to process your claim as quickly as possible, you can take this form with you to your medical practitioner to complete (each new medical condition). When fully completed, send it to us with your claim. If you choose not to do so, it may be necessary for Global Response to send you this form for completion by your medical practitioner.

What's next?

Send your completed form to us together with your claims documents, including invoices, payment receipts and any medical reports using **one** of the following options. Please note that you must keep your original invoices and receipts for 6 months for audit requirements other than sending by post when originals should be included, in which case photocopies should be kept.

Online: www.alchealth.com/claims.htm
Email: claims@alchealth.com
Fax: +44 (0) 330 333 6687
Post: ALC Health Claims Team, Global Response Ltd
PO Box 1114 Cardiff CF11 1UL United Kingdom

To be completed by the patient

1 Patient's details and consent

Title

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Patient's first name(s)

Patient's surname

Date of birth (DD-MM-YYYY)

Patient's Customer and Policy Number

Condition ID/Case Reference

Patient's contact numbers

T: M:

Patient's email address

I, the patient, hereby authorise Global Response to obtain further medical information from the doctor completing this medical certificate should it be required for the purpose of this claim.

I, the patient, consent and agree to Global Response disclosing and sharing my medical and/or health information contained in this form, or any health records and/or any medical reports with underwriters, XL Insurance Company SE, and/or ALC Health for the sole purpose of administering any and all claims arising from my medical policy.

Signature

Date (DD-MM-YYYY)

To be completed by the Medical Practitioner or Treating Doctor

2 Medical details

Date the patient first registered with you/the clinic/the hospital: (DD-MM-YYYY)

Please provide details of the patient's symptoms:

Was the patient referred to you?

Yes ☐ No ☐

If yes, please provide referral details.

When did the patient first notice these symptoms?

When did the patient first present these symptoms to you or any other Medical Practitioner?

To the best of your knowledge, has the patient ever suffered from these or any related symptoms in the past?
If so, please provide details:

Please provide details of any tests and investigations that the patient has had, and the results of these:

Has a diagnosis been made?

Yes ☐ No ☐

If yes, please confirm medical condition?

Is it: Provisional? ☐ Final? ☐

Would you consider the condition to be? Acute? ☐ Chronic? ☐ An acute episode of a chronic condition? ☐

If this diagnosis is related to any previous condition suffered by the patient, please provide details, including any previous investigations, treatment received and the relevant dates:

Details to be provided | Date (DD-MM-YYYY)

Is there any underlying cause or condition? If so, please provide details:

Is the condition the result of an accident?

Yes ☐ No ☐

If yes, was the patient under the influence of alcohol or any other intoxicating substance at the time of the accident?

Yes ☐ No ☐

What treatment has been recommended to the patient for this condition?

If the patient has been referred for complementary treatment, please indicate the type and the number of sessions:

Chiropractor: ☐ Osteopath: ☐ Homeopath: ☐ Acupuncturist: ☐

Dietician: ☐ Traditional Chinese Medicine: ☐ Podiatrist: ☐ Number of sessions:

What further treatment is required, if any?

Have you referred the patient to another Doctor? If yes, please provide the name and contact details of the Doctor you have referred them to:

If the claim is related to pregnancy, please confirm the following:

Date of last menstrual period:

Date pregnancy was confirmed:

Estimated date of delivery:

Is the pregnancy considered to be high risk? Yes ☐ No ☐

Qualifications

I am the patient's medical practitioner or treating doctor and I confirm the information I have provided is correct to the best of my knowledge.

Name of Doctor

Address

Postcode Country

Telephone

Signature

Date signed (DD-MM-YYYY):

Practice Stamp

ALC56250A 13/12/19