Medical Certificate

MIKE HENRY

This certificate collects personal information about you so we can consider your request for insurance. Mike Henry, a business division of IAG New Zealand Limited, is collecting this information. It will be held at P O Box 298 Shortland Street Auckland. You may request access to, and correction of, this information according to the provisions of the Privacy Act 1993.

Please return by fax to **09 985 0355**. For more information please contact Mike Henry on **0800 657 744**.

Contact Email: Contact Fax No:

Part A: To be completed by the applicant

Name: Weight: Height: Age:

Address:

Telephone Contact:

Countries to be visited:

Main destination:

Departure Date: Return Date:

Have you made any Medical Travel Insurance claims within the last three years? **YES / NO** *(Delete non-applicable)*

I consent to the information supplied on this Medical Certificate being released to the insurer or its agent and for them to contact my doctor for further medical information for the purpose of this insurance or for any subsequent claim that may occur.

Applicant to Sign: Date:

Part B: To be completed by the applicant's doctor

Doctor's Phone Number: Doctor's Name: Date:

DECLARATION: I confirm that this medical certificate has been completed by myself and that I am the Medical Doctor as detailed above.
(NOTE: We may contact you by telephone if more information or further clarification is required)

Doctor's Signature:

Is the patient fit to undertake the proposed journey without adverse effects? **YES / NO** *(Delete non-applicable)*

Do you anticipate the patient requiring medical attention? **YES / NO** *(Delete non-applicable)*

1. HEART CONDITION **Date diagnosed:** **Type:**

   Medication/surgery:

   Has the patient seen a specialist/been hospitalised in last 6 months **YES/NO** *(Delete non-applicable)*
   (If yes, please attach any specialist letters, discharge summary and test results you may have on file).

   Angina on exertion? **YES/NO** *(Delete non-applicable)*

   Angina on rest? **YES/NO** *(Delete non-applicable)*

   Hypertension? **YES/NO** *(Delete non-applicable)*

   Last three blood pressure readings: *(Reading and date)* 1) 2) 3)

2. RENAL Date diagnosed: Type:

Condition is controlled: YES/NO *(Delete non-applicable)*

Medication/surgery:

Other related condition? Details:

Date of last hospitalisation: Date of last specialist/outpatients appointment:

3. CIRCULATORY Date diagnosed: Type:

Condition is controlled: YES/NO *(Delete non-applicable)*

Medication/surgery:

Other related condition? Details:

Date of last hospitalisation: Date of last specialist/outpatients appointment:

4. RESPIRATORY CONDITION Date diagnosed: Type:

Condition is controlled: YES/NO *(Delete non-applicable)*

Medication/surgery:

Last three peak flow readings: *(Reading and date)* 1) 2) 3)

5. CANCER Date diagnosed: Type:

Condition is controlled: YES/NO *(Delete non-applicable)*

Condition is Metastatic? YES/NO *(Delete non-applicable)*

Medication/surgery:

Date of chemo/radiotherapy: Date of last check up:

Date of next check up:

6. HOSPITALISATION / SPECIALIST

Has the patient seen a specialist/been hospitalised in last 6 months YES/NO *(Delete non-applicable)*

If yes, please attach copies of all discharge summaries/specialist letters and test results

7. TERMINAL CONDITION YES/NO *(Delete non-applicable)*

Details:

8. MEDICAL CONDITIONS CURRENTLY UNDERGOING REFERRAL/INVESTIGATION YES/NO *(Delete non-applicable)*

Details:

9. OTHER CONDITIONS AND/OR MEDICATIONS TAKEN YES/NO *(Delete non-applicable)*

Details: