Claims Department
P.O. Box 47
Stevens Point, WI 54481-0047
Fax: 715.295.1113 or 715.345.1141
www.travelguard.com

AIG Claims Inc. is a wholly owned subsidiary of AIG and provides claims administration for Travel Guard® travel insurance products.

Medical Certificate

Note:

- Please answer all questions. Incomplete form will cause a delay in our assessment. Please complete in CAPITALS.
- All information is treated as private and confidential

TO BE COMPLETED BY INSURED	
1. Patient's Name:	2. Patient Date of Birth (MM/DD/YYYY):
3. Insured's Name:	4. Insured's Relationship to Patient:
5. CLAIM NO:	6. Scheduled Departure Date (MM/DD/YYYY):
7. **Insurance Purchase Date (MM/DD/YYYY):**:	8. Scheduled Return Date (MM/DD/YYYY):

ATTENDING PHYSICIAN'S STATEMENT – *TO BE COMPLETED BY PHYSICIAN*

1. On the Insurance Purchase Date **(see #7 above)**, was the Patient:

			Comments:
A) Under Your Care:	YES	NO	
B) Medically Able to Travel:	YES	NO	
C) Taking any Medication Relevant to the Above Condition(s):	YES	NO	
D) Undergoing any Tests or Waiting for Results of any Tests:	YES	NO	
E) Aware of the Condition:	YES	NO	

2. Diagnosis – Nature of Injury or Sickness causing Cancellation/Interruption: (Please be specific)

a) Primary Diagnosis (ICD10):	
b) Secondary Diagnosis (ICD10):	

3. a) When did symptoms first appear or injury occur? (MM/DD/YYYY)

b) When did Patient first consult you for the above noted condition(s)? (MM/DD/YYYY)

c) If Patient was referred from another Physician, name of other Physician:	Telephone Num:
d) If Patient referred to another Physician, name of other Physician:	Telephone Num:
e) Names & Contact Numbers of all other Physicians involved:	Telephone Num:

4. Date when Patient's medical condition last controlled and stable? (MM/DD/YYYY)

5. Dates of all medical visits, treatment or care as it relates to the condition(s) causing Cancellation/Interruption of Travel:

6. What date did you advise there was a need to cancel or interrupt the travel arrangement? (MM/DD/YYYY)

7. Give full descriptions of illness or injury that caused the cancelation or interruption of travel:

Physician / Specialist Declaration

I have examined the patient and / or referred to their medical records and declare that the information given is correct and no relevant details have been withheld.

Physician / Specialist Name:	Specialty:	Physician Remarks:
Address and Phone Number:		
Physician / Specialist Signature:	Date Signed (MM/DD/YYYY)	

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- Please provide contact information for all Physicians or any Provider of Medical Services that the person having the Sickness or Injury had seen 180 days prior to the purchase of this insurance policy through the Scheduled Departure Date.
- All information is treated as private and confidential

Provider #1			
Hospital / Clinic Name:			
Physician Name:			
Address:			
City, State/Province, Zip			
Country:			
Telephone Number:		Fax Number:	
Email Address:			
Illness / Injury:			

Provider #2			
Hospital / Clinic Name:			
Physician Name:			
Address:			
City, State/Province, Zip			
Country:			
Telephone Number:		Fax Number:	
Email Address:			
Illness / Injury:			

Provider #3			
Hospital / Clinic Name:			
Physician Name:			
Address:			
City, State/Province, Zip			
Country:			
Telephone Number:		Fax Number:	
Email Address:			
Illness / Injury:			