Further Claims
Medical certificate

Important notice

Material facts

There is a duty to disclose all material facts that could influence QBE Insurance's decision to accept this insurance and, if so, on what terms. You need to disclose facts both known to you and those which you could have been reasonably expected to know about. If you are in any doubt as to whether or not a fact may be material, you should disclose it to ensure that any cover granted is not prejudiced.

Non-disclosure/misstatement

If there is failure to comply with the duty of disclosure, QBE may be entitled to avoid the contract altogether, and therefore decline to pay any claim.

Jurisdiction

Except where the parties agree otherwise, the laws of New Zealand apply to this form and any dealings between the parties arising from this form. The New Zealand courts have exclusive jurisdiction in relation to any disputes that may arise.

How to complete this form

- This certificate is to be completed by the medical attendant as a clearance, or if the patient remains disabled, and only if an initial claims medical certificate has been completed
- All questions must be answered fully and, if completing this form by hand, please ensure you write clearly.
- If you are completing this form electronically, please open it using the latest version of Adobe Reader. Use your mouse/trackpad to take the cursor to the next editable field. Boxes can be ticked either by using your mouse/trackpad or by hitting 'enter'. Upon completion, please print out this form and sign the declaration.
- The signed form should then be posted, or emailed, to the broker.

A Applicant details

This certificate is to be completed by the medical attendant as a clearance, or if the patient remains disabled, and only if an initial claims medical certificate has been completed.

1. **Full name of Insured**

2. **Claim number**

3. **Patient's occupation**

4. **Did you complete the Initial Claims Medical Certificate for the patient?** Yes ○ No ○

5. **I have examined the patient on** dd / mm / yyyy and he/she is:

   (a) fit to resume their Usual Occupation on dd / mm / yyyy ; or

   (b) still prevented from attending to their Usual Occupation and is likely to remain so for a period of: weeks

If 5(b) is applicable, please complete the following:

6. **What is the cause of the patient's disability?**

QBE Insurance (Australia) Limited
ABN 78 003 191 035 – Incorporated in Australia
PO Box 44, Auckland 1140
Phone 64 9 366 9920 | Fax 64 9 366 9930 | www.qbe.co.nz

7. **What treatment/medication is the patient receiving?**

8. **Has the patient been referred to a specialist?** Yes No

If 'Yes', please advise the name and address of specialist.

9. **Would the patient benefit from attending a rehabilitation programme?** Yes No

If 'Yes', are you aware of a suitable programme? Yes No

If 'Yes', please provide details below.

Signed by medical attendant .....

Date dd / mm / yyyy

Printed name

Phone

Position

Mobile

Email address

SAVE AS PRINT