Medical certificate form.

Patient's details.

Patient name

Date of disability (DD/MM/YYYY)

Pre-disability occupation

Policy number

Original diagnosis

Medical condition (to be completed by treating medical practitioner).

Current diagnosis(ses) or problem list

Current symptoms

Current medications

Current treatment plan

Last specialist assessment

Specialist name

Speciality

Date (DD/MM/YYYY)

Is there any upcoming specialist referral(s) required or planned? ◯ Yes ◯ No

If yes, please advise what specialist appointments or referrals are planned and when these are likely to happen

Medical certificate form.

Work capacity.

Does the medical condition(s) prevent the insured person from working in their own occupation?

Full time ◯ Yes ◯ No

Part time ◯ Yes ◯ No

If the current medical condition prevents the insured person from working in their pre-disability occupation, please advise the medical barriers preventing them from doing so

If the patient has some capacity to work, what tasks are they able to perform?

Hours per week

When do you expect a change in the patient's work capacity?

Are you completing any other medical certificates for this person? ◯ Yes ◯ No

If yes, for whom ◯ ACC ◯ Other insurer ◯ WINZ ◯ Other

Declaration.

I have seen and assessed this patient today. All of my statements above are accurate and correct to the best of my knowledge.

Doctor name/practice stamp

Signature

Date (DD/MM/YYYY)

Please return your completed form and any accompanying documents to:

@ claims@fidelitylife.co.nz 09 303 5732 Freepost 1893, PO Box 37275, Parnell, Auckland 1151.

If you have any questions please contact us on 0800 88 22 88, option 2.