Abelard
UNDERWRITING AGENCY

MEDICAL INITIAL CLAIMS NOTIFICATION FORM

Certificate from usual Medical Practitioner				
Name:		Tel:		
Address:		Fax:		
Full Name of patient:				
What is the definitive diagnosis?				
When did signs and symptoms first occur?				
What date was the condition first diagnosed:				
Does the present disability relate in any way to previous injuries or pre-existing conditions?			Yes	No
If yes, please provide details				
Are there any contributory ailments that may be related to the condition?			Yes	No
If yes, please provide details				
How long have you been the patients medical practitioner?				
Details of any other attending doctor / specialist:				
Name:		Tel:		
Address:		Fax:		
Please provide any additional information which you feel may be relevant:				

_____ _____

Signature Date