Heath Lambert Group

GROUP TRAVEL INSURANCE
MEDICAL REFERRAL

To be completed by the Insured Person

Name of Scheme: Cleveland Police Federation Joint Branch Board **Policy Number:** 54UK474589

Name of Insured Person: ..... **Date of Birth:** .....

If not member, please state name of Member: ..... **Relationship:** .....

Home Address: .....

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Please provide brief details of your complaint:
(including date diagnosed/period suffered, current medication/treatment - please continue overleaf if required)

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Dates of Travel: .....

Date of Booking: .....

Destination: .....

ACE European Group Limited and its group companies will use the information you provide on this questionnaire, together with other information for the purposes of underwriting and administering your policy, customer services and paying claims.
Where you have answered any questions requiring the disclosure of sensitive personal data or provided additional information, including any medical information from any doctor both now and in the future, by signing this form, you also consent to ACE using this information for the above purposes.
You also consent to our transferring your information to other countries for the purposes outlined above. If we do make such a transfer we will put a contract in place to ensure your information is protected.

*I hereby **confirm my consent** as required by the Data Protection Statement above.*
I also confirm that the below referenced Consultant/GP has my consent to complete this form on my behalf:-

Signed by Insured Person: ..... **Date:** .....

To be completed by Treating Consultant or Specialist (or GP if not applicable) – <u>where possible, please endorse with official stamp</u>

Name of Consultant/GP:
(Delete as appropriate) .....

Address: .....

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The above named person is a patient at this hospital/practice and I hereby confirm that to the best of my knowledge he/she:-

- ***is fit to travel for the outward and return journey on the chosen mode of transport***
- ***for the duration of the stay at the specified destination(s) and for any intended activities***
- ***is unlikely to require any medical treatment during the forthcoming trip.***

Signed: ..... **Date:** .....

Please note: **This policy excludes cover where a Journey is undertaken i) against the advice of a Qualified Medical Practitioner, ii) where any terminal complaint has been diagnosed, or iii) to obtain medical treatment. If cover is granted, then the policy excludes the cost of purchasing repeat/prescribed medication.**