Medical Certificate

To be completed by the Life Assured's attending physician at the Life Assured's expense

1 Life Assured Details

Policy Number

Date of Birth DD / MM / YYYY

Name of Life Assured

Address Street

Suburb

City

Postcode

Pre-Disability Occupation

Pre-Disability Hours Worked

2 Questionnaire

Diagnosis (causing work incapacity)

Problem List (contributing to work incapacity)

On what date will the above patient be fit to return to part-time or restricted work? Date / / Capable hours

On what date will the above patient be fit to return to their normal work? Date / / Capable hours

If there are no fit to return to work dates, please list the tasks at the patient's work they are able to do

If there are no fit to return to work dates, please list the tasks at the patient's work they are unable to do

Are you completing any other medical certificates for the above patient? If so, please provide details

Please list medications and dosages

Please list diagnostic investigations undertaken since the last medical certificate

Please provide details of any other relevant treatment providers for the above patient

3 Other Questions

Case Manager to complete as relevant

Any other comments or observations you would wish to make

Would you like an AIA Medical Adviser or Case Manager to phone you to discuss this case? (you are able to invoice AIA reasonable costs for this discussion)

☐ Yes ☐ No

Best day to call

Best time to call

Telephone

4 Attending Physician's Declaration

I have personally examined the Life Assured named above today and to the best of my knowledge the information given above is accurate and correct.

Name

Address

Phone

Fax

Email

Medical Specialty

Signature X

Date DD / MM / YYYY

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