

Section 12: Fast Cover Medical Authority Form

Complete this form if your claim is due to an accident, illness, disability or death.

The form must be completed by the patient (injured, ill or disabled person) whose illness or injury resulted in this claim or Executor of the Estate in the event of a death.

I authorise Fast Cover or its representatives to obtain from any person or organisation any information regarding treatment for the condition(s) which resulted in this claim. I acknowledge that a photocopy of this authorisation shall be considered as valid as the original.

Claim Number:

Claim Number:

Patients Full Name:

Patients Date of Birth:

Patients Signature:

Executor of the Estates Full Name (if applicable):

Executor of the Estates Signature (if applicable):

Name of Patients Usual Doctor/Dentist in Australia:

Doctor/Dentists Phone Number:

Doctor/Dentists Fax Number:

Doctor/Dentists Email Address:

Doctor/Dentists Postal or Practice Address:

Suburb:

State:

Postcode:

If your trip was cancelled or postponed before you left, you must have the Medical Certificate in Section 13 completed by the usual treating Doctor or Dentist of the patient (injured, ill or disabled person) **whose illness or injury resulted in this claim**. If we need further information from a Specialist we will let you know.

Please return completed form to Fast Cover

Email Address claims-fch@fastcover.com.au (Please include claim number in email subject)

Phone Number 1300 409 322

Fax Number 02 8883 7002

Postal Address Fast Cover Claims
Locked Bag 2010
St Leonards NSW 1590