

Veterinary Fees Claim Form
Pet Insurance Claims Department
7th Floor, St Philips Point, Temple Row, Birmingham B2 5AB

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|--------------------------|----------------------|-------------|--------------------------|---------|--------------------------|
| Name: | <input type="text"/> | Pet's Name: | <input type="text"/> | | |
| Address: | <input type="text"/> | Breed: | <input type="text"/> | | |
| | | Dog: | <input type="checkbox"/> | Cat: | <input type="checkbox"/> |
| | | Male: | <input type="checkbox"/> | Female: | <input type="checkbox"/> |
| Daytime Tel No: | <input type="text"/> | Policy No: | <input type="text"/> | | |
| Broker/Agent Name | <input type="text"/> | | | | |

2 If you have any questions about your claim or completing the form please call 0845 279 7249.

Please read your policy terms and conditions carefully before filling in this form.
Sections 3), 4) and 5) must be completed by the attending veterinary practice.
If you are claiming for complimentary treatment the claim form and the invoices must be countersigned by your vet.
You must pay the vet for any costs we cannot pay.
We will not pay: a) more than the maximum benefit
 b) the excess for each condition
 c) any treatment excluded in the policy terms and conditions or on your certificate of insurance
 d) any administration charges

1) To be completed by the policyholder

Please provide details of your previous veterinary surgeon if your pet has been registered at the treating practice for less than 3 years.

| | | | |
|----------|----------------------|---------|----------------------------------|
| Name: | <input type="text"/> | Tel No: | <input type="text"/> |
| Address: | <input type="text"/> | Fax No: | <input type="text"/> |
| | | From: | <input type="text" value="/ /"/> |
| | | To: | <input type="text" value="/ /"/> |

The name of each illness or accident you are claiming for and the date you first noticed signs or symptoms:

| | | | | |
|----|----------------------|-------|----------------------------------|--|
| 1) | <input type="text"/> | Date: | <input type="text" value="/ /"/> | |
| 2) | <input type="text"/> | Date: | <input type="text" value="/ /"/> | |

To whom should the claim be paid? To yourself Direct to the veterinary surgeon

2) Declaration - to be completed by the policyholder

I declare that the details given are correct to the best of my knowledge and agree that any vet who has treated my pet may provide any information the company may require to process my claim. I confirm that payment is to be made as indicated above.

| | | | |
|-----------|----------------------|------|----------------------------------|
| Signed By | <input type="text"/> | Date | <input type="text" value="/ /"/> |
|-----------|----------------------|------|----------------------------------|

3) Case History - to be completed by the veterinary

| | First claim | Second claim |
|--|--|--|
| Date first registered: | / / | |
| Dates of treatment: | From / / To / / | From / / To / / |
| Diagnosis: | | |
| Treatment details: | | |
| If the pet has been seen for a similar or related condition please give details: | | |
| Have you claimed for this condition before? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |

4) Veterinary Fees - to be completed by the veterinary practice

Please attach an itemised invoice listing dates, treatments and medication, for each illness or injury.

| | | |
|--|---|---|
| Total cost of treatment: | £ | £ |
| If house visits are included would moving the pet have damaged its health? | Yes <input type="checkbox"/> No <input type="checkbox"/> Cost £ | Yes <input type="checkbox"/> No <input type="checkbox"/> Cost £ |
| If the pet was euthanased are cremation costs included? | Yes <input type="checkbox"/> No <input type="checkbox"/> Cost £ | Yes <input type="checkbox"/> No <input type="checkbox"/> Cost £ |

5) Declaration - to be completed by your vet or the person authorised by the vet to fill in and sign

| | | |
|--|--|--|
| <ul style="list-style-type: none"> I have completed this claim form. As far as I know the information is correct. The fees charged are no higher than the normal practice fees. | Signature: <input type="text"/> Name: <input type="text"/> Date: / / | Practice name, address and telephone No: <input type="text"/> <input type="text"/> |
|--|--|--|