

Pet Claim Form - Vet's Fees

(Use this form for up to 2 separate injuries or illnesses per pet. If you want to claim for more than two illness/injuries and/or more than one pet please use an additional form.)

Policy No:
Date Downloaded:



CLAIM FORMS RECEIVED WHICH ARE INCOMPLETE WILL BE RETURNED TO THE POLICYHOLDER.

1 Your Details *(This section to be completed by the policyholder)*

Your Name			
Address			
		Postcode	
Daytime Tel. No.		Mobile No.	
Evening Tel. No.			
Email			

2 Pet's Details *(This section to be completed by the policyholder)*

Name of pet			
Type of pet	<input type="checkbox"/> Dog	<input type="checkbox"/> Cat	
Sex of pet	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Breed of pet			
Age of pet			
Date of purchase		Price paid	£
Injury, illness or disease you are claiming for and the date when you first noticed the clinical signs.	Claim A		
	Date	Time	
	Claim B		
	Date	Time	

If your pet has been involved in a road accident please use a separate sheet to tell us exactly how it happened.

Attending vet Practice	Name			
	Address			
		Postcode		
Practice where your pet has been previously registered, if applicable.	Name			
	Address			
		Postcode		

Has your pet suffered with, or have you claimed for this condition previously?	Claim A	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Claim B	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your pet been routinely wormed?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your pet been routinely vaccinated?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your pet been neutered?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
In the event of settlement becoming due, to Whom should payment be made?	<input type="checkbox"/> Me	<input type="checkbox"/> Vet	<input type="checkbox"/> Other Name
Could this claim potentially be covered under any other policy of insurance? If Yes, please provide full details.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Declaration *(This section to be completed by the policyholder)*

I hereby declare that the details given by me, are to the best of my knowledge, true and complete. I authorise the vet to provide, upon request, all copies of medical records of pets treated on my behalf.

Policyholder's Signature _____ Date _____

CONTACTING US

If you have any queries, please call  03300 243 556

REQUIREMENTS

YOU Complete sections **1** and **2**
YOUR VET Completes section **3** (Overleaf)

IMPORTANT NOTES

- LIABILITY**
The issue of this form does not constitute an admission of claim liability by pet-insurance.co.uk
- REQUIREMENTS**
Please ensure that all sections are completed by you and your vet as indicated. **Please ensure that your vet includes your pet's medical history with the claim form.** The form must be returned to the address shown below within 90 days. Email or Fax copies of the claim can be sent in advance.
- SETTLEMENT**
In the event of claims settlement becoming due **We** will issue settlement by **We** BACS transfer. Where bank account details have not been provided or this is not possible, settlement will be despatched by cheque. Settlement will be issued to **You** unless otherwise requested. **You** can select an alternative payee by ticking the relevant box on the claim form **You** fill in and by providing the third party name.
- RESERVATION OF RIGHTS**
pet-insurance.co.uk reserve the right to appoint loss adjusters or veterinary consultants to review the claim and to request further information from current or previous vets or previous insurers.
- EXCESS**
You will have to pay your vet the excess and any unrecoverable items E.G. Admin costs, claim form completion costs etc.

Thorpe Underwood Hall
 Ouseburn, York, YO26 9SS
 Tel: 03300 243 556
 Fax: 03300 242 971
 email claims@pet-insurance.co.uk
 web: www.pet-insurance.co.uk

Veterinary Fees Claim Form

To be Completed by **YOUR Vet.**

PLEASE NOTE THAT IF ANY QUESTIONS ARE LEFT UNANSWERED IT IS LIKELY TO CAUSE A DELAY IN THE ASSESSMENT OF THE CLAIM.

Policyholder Name:
Address:
Policy No:

3 Details of Condition and Treatments given. *(This section to be completed by your vet)*

Name of pet		Age of pet	
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How long has your practice known this animal?

Please can you provide a copy of the pet's full previous medical/clinical history for the duration of ownership. If there is no history available or if you cannot provide the full history please state the reason why (e.g. we are the referral practice/first time this pet has been seen by this practice).

Illness or Injury - Claim A

Illness or Injury - Claim B

Diagnosis or give clinical signs/symptoms if you have not made a diagnosis.

Dates and Costs of treatment.

From	<input type="text"/>	To	<input type="text"/>
Cost	<input type="text"/>		

From	<input type="text"/>	To	<input type="text"/>
Cost	<input type="text"/>		

Please ensure all relevant invoices are attached.

In your opinion how long had the animal had this complaint prior to your first consultation?

(As noted by you, stated by the client or on the pet's record).

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If the animal was presented at an out of hours surgery, or subject to a home visit, was the condition life endangering?

Yes No

Yes No

Have you or do you intend to refer this animal to another vet?

Yes No

If yes, please state the name and address below and include a referral report:

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Yes No

If yes, please state the name and address below and include a referral report:

--

Has the pet been seen before, for this illness or injury?

Yes No

Yes No

Has the pet been seen before, for any similar, related illness or injury or clinical signs?

Yes No

Yes No

In your opinion:

Is it likely the condition suffered will require further treatment/medication?

Yes No

Yes No

If YES, is it likely the condition suffered will require treatment/medication for the rest of this pet's life?

Yes No

Yes No

If NO, once treatment/medication has ended is this pet at a higher risk of the condition reoccurring than a pet which has never suffered it before?

Yes No

Yes No

In the event of death please advise us of:

Cause of death	<input type="text"/>
Date	<input type="text"/>

If the animal was put to sleep, please indicate why:

PLEASE NOTE THAT IF ANY QUESTIONS ARE LEFT UNANSWERED IT IS LIKELY TO CAUSE A DELAY IN THE ASSESSMENT OF THE CLAIM.

Declaration *(This section to be completed by your vet)*

The RCVS regard an insurance claim form once signed by a vet as being a veterinary certificate with attendant serious implications. I hereby certify that I have checked the information in Section 3 above and that to the best of my knowledge it is correct. The fees I have charged are no higher than my normal practice fees.

Vet Name	<input type="text"/>	MRCVS/FRCVS
Practice Name	<input type="text"/>	
Practice Address	<input type="text"/>	

Vet's Signature _____ Date _____



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