

Claim Form for Veterinary Fees

Please make sure this form is completed clearly and in full to ensure the correct assessment of your claim.
 Please complete a separate form for each pet.
 Please attach receipts for all treatment being claimed.
 Please complete using a black pen and BLOCK CAPITALS.

Section 1 About you (to be completed by the policyholder)

Schedule number

Full name

Address

 Postcode

Email address

Telephone number Mobile number

Section 2 About your pet (to be completed by the policyholder)

Pet's name

Is this pet a Dog Cat Is this pet Male Female

Breed Pet's age Years Months

Is your pet insured with any other company? Yes No

If Yes, which company

Section 3 Details of your pet's illness or injury (to be completed by the policyholder)

What condition(s) are you claiming for and the date you first noticed any signs?

1. Date / /

2. Date / /

Did the condition result in the death of your pet? Yes No

Date of death / /

Veterinary surgeries where your pet has been registered or treated in the past two years (if there is more than one, please use a separate piece of paper)

Name

Address

 Postcode

Telephone number

Date: from / / to / /

If this is the first claim for an illness please ask your vet to attach a full clinical history for the last two years

Section 4 Declaration (to be completed by the policyholder)

I have checked the information on this claim form (sections 1-3) and confirm that it is all correct to the best of my knowledge and belief.

Signature 

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INCOMPLETE CLAIMS FORMS WILL BE RETURNED TO THE POLICYHOLDER

Your vet needs to complete this page

Section 5 General information

When was this pet first registered at your practice?

Date / /

If this pet has been referred please give the name, address and telephone number of the practice which referred it

Name

Address

Postcode

Telephone number

In connection with the treatment being claimed did you:

Make a house visit?

Yes

No

Provide out of hours treatment?

Yes

No

If Yes, please clarify why the house visit/out of hours treatment was essential for the health of the pet

Is any part of this claim for a condition the pet can be vaccinated against?

Yes

No

If Yes, were the pet's vaccinations up to date at the time of treatment?

Yes

Please give date of last vaccination / /

No

Don't know

Please certify that any prescription diet food is specifically recommended by the manufacturer for the condition treated

Yes

No

N/A

Section 6 About the illness or injury

Condition 1

Name of illness or injury (if no diagnosis has been made please give clinical signs)

Is this claim a continuation?

Yes

No

When did this illness or injury begin (as noted on your records)? / /

Treatment dates: from / / to / /

Did death or euthanasia result from this illness or injury?

Yes

No

Date of death / /

If the pet was put to sleep, did you recommend this?

Yes

No

To your knowledge has this pet been seen for:

This illness or injury

Yes

No

Any similar or related illness or injury

Yes

No

Any similar or related clinical signs

Yes

No

If Yes, please provide the history with dates:

Date / /

Date / /

Total amount claimed (inc VAT)

£ -

Condition 2

Name of illness or injury (if no diagnosis has been made please give clinical signs)

Is this claim a continuation?

Yes

No

When did this illness or injury begin (as noted on your records)? / /

Treatment dates: from / / to / /

Did death or euthanasia result from this illness or injury?

Yes

No

Date of death / /

If the pet was put to sleep, did you recommend this?

Yes

No

To your knowledge has this pet been seen for:

This illness or injury

Yes

No

Any similar or related illness or injury

Yes

No

Any similar or related clinical signs

Yes

No

If Yes, please provide the history with dates:

Date / /

Date / /

Total amount claimed (inc VAT)

£ -

PLEASE ENCLOSE FULL RECEIPTED INVOICES TO SUPPORT THIS CLAIM.

IF THIS IS THE FIRST CLAIM FOR AN ILLNESS PLEASE ATTACH A FULL CLINICAL HISTORY FOR THE LAST TWO YEARS.

Section 7 Veterinary practice declaration

I have checked the information on this claim form and confirm that it is all correct to the best of my knowledge and belief

Name

Practice name

Position in practice

Email address

Vet stamp

Signature

X

Date / /

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