

# Claim Form for Veterinary Fees

New Condition

Continuation Condition

Previous claim no \_\_\_\_\_

Please make sure that this claim form is completed CLEARLY and IN FULL to ensure the correct assessment of your claim form.

If you are submitting a CONTINUATION CLAIM please complete the YELLOW SHADED BOXES MARKED WITH A 'C'. Please use a BLACK PEN and BLOCK CAPITALS.

**We're happy to help!**  
If you have any questions call us on  
**0845 074 4406**



**1. Policyholder to complete** POLICY NUMBER C

**2. Policyholder to complete** ABOUT YOU

Policyholder's name C

Daytime telephone no \_\_\_\_\_

Email address \_\_\_\_\_

Policyholder's address \_\_\_\_\_

Postcode \_\_\_\_\_

Please tick here if this is different to the address on your Certificate of Insurance

**3. Policyholder to complete** ABOUT YOUR PET

Pet's name C

Pedigree name \_\_\_\_\_

Is your pet a Dog  Cat  Rabbit

Pet's date of birth / / Male  Female

Breed \_\_\_\_\_

**If this is the first claim you are submitting for your pet you must include a full clinical history from all of the vets that your pet has been registered with. Your claim will be delayed if this is not included.**

**4. Policyholder to complete** DETAILS OF YOUR PET'S ILLNESS

What condition(s) are you claiming for?

Condition 1 \_\_\_\_\_

Condition 2 \_\_\_\_\_

**For each condition, please tell us the date you noticed any signs that your pet was unwell before booking an appointment with your veterinary practice. Your claim may be delayed if we do not have this information**

Date / / for Condition 1

Date / / for Condition 2

Did the illness or injury result in the death of your pet? Yes  No

Date of death / /

Please tell us the name and address of veterinary surgeries where your pet has been registered before or the details of the vet that referred you (If there is more than one, please use a separate piece of paper)

Name \_\_\_\_\_

Address \_\_\_\_\_

Postcode \_\_\_\_\_

Telephone no \_\_\_\_\_

Date: from / / to / /

**5. Policyholder to complete** PAYEE DETAILS C

Cheques will be automatically made payable to the policyholder(s) named on your Certificate of Insurance

**PLEASE COMPLETE ONE OF THE FOLLOWING**

Please note we will not pay your vet unless we have previously agreed with them to do so. Please check with your vet

**A. Pay Vet** - please tick C

I/We have checked with my vet/our vet and would like this claim paid directly to them

Please write the name of the veterinary practice here \_\_\_\_\_

Please sign here **X**

Date / /

Are you happy for Pet Plan Ltd to provide the veterinary practice identified on this form with information about your policy in respect of this claim? Yes  No

**B. Pay Policyholder(s)** - please tick C

I / We wish the claim to be paid to the policyholder(s) named on the Certificate of Insurance

Please sign here **X**

Date / /

**C. Pay one Policyholder (Joint policy only)** - please tick

We wish one policyholder to be paid only

Policyholder to be paid \_\_\_\_\_

**Both policyholders must sign** **X**

**X**

Date / /

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

**IMPORTANT NOTES**

- Pet Plan Ltd administers the policy on behalf of Allianz Insurance plc which underwrites the policy
- If the claim is being faxed, please retain all the original copies of the claim form and receipts

- Please use a separate claim form for each pet
- Please send completed claim forms including copies of all receipts to:  
**Pet Plan Ltd, Great West House (GW2), Great West Road, Brentford, Middlesex TW8 9DX**

Pet Plan Ltd is a subsidiary of Allianz Insurance plc which is authorised and regulated by the Financial Services Authority (FSA). Allianz Insurance plc's FSA Register number is 121849. This can be checked by visiting the FSA website at [www.fsa.gov.uk/register](http://www.fsa.gov.uk/register) or by contacting the FSA on 0845 606 1234.

Allianz Insurance plc underwrites the policy and Pet Plan Ltd administers the policy.

**INCOMPLETE CLAIM FORMS WILL BE RETURNED TO THE POLICYHOLDER**

# ASK YOUR VET TO COMPLETE THESE THREE SECTIONS

## 6. Vet to complete

### GENERAL INFORMATION

When was this pet first registered at your practice? / /

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

Name

Address

Telephone no

In connection with treatment claimed did you:

Make a **house visit**? Yes  No

Or provide **out of hours treatment**? Yes  No

If **Yes**, why was the house visit/out of hours treatment necessary?

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 time of treatment?

Yes  Please give date of last vaccination / / No  Don't know

Is any part of this claim for **dental treatment**? Yes  No

If **Yes**, please enclose a full clinical history over the last 2 years. If this is not attached this will delay the client's claim

Is any part of this claim for treatment of a **urinary problem**? Yes  No

If **Yes**, is the cost of diet food included in this claim? Yes  No

If **Yes**, please provide the name of the diet food being used and total cost being claimed

Name Amount £ -

Were crystals present? Yes  No

If **Yes**, are the crystals Oxalate  Struvite  Other

If other, please specify

Please give dates and results of last two urine tests

Date / / Result

Date / / Result

## 7. Vet to complete

### ABOUT THE ILLNESS OR INJURY

#### Condition 1

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

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

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

To your knowledge has this pet been seen before 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) £ - C

PLEASE ENCLOSE FULL INVOICES TO SUPPORT THIS CLAIM

## 7. Vet to complete

### ABOUT THE ILLNESS OR INJURY

#### Condition 2 (If relevant)

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

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

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

To your knowledge has this pet been seen before 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) £ - C

PLEASE ENCLOSE FULL INVOICES TO SUPPORT THIS CLAIM

## 8. Vet to complete

### DECLARATION BY THE VETERINARY PRACTICE

This practice is authorised to have claims paid direct Yes  No

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

Position in practice

Petplan Practice no

Email address

Vet stamp

Signature X

Date / /