



# Pet Claim Form - Veterinary Fees

 New Condition 

 Continuation Condition 

Policy Number: \_\_\_\_\_

\*The issue of this claim form does not constitute an admission of claim liability by Animal Friends Insurance Services Ltd.

**\*\* Please submit your fully completed claim form with a full clinical history from all of the vets that your pet has been registered with. Failure to do so may result in your claim being delayed.**

## ABOUT YOU - Policyholder to complete

Policyholder's name \_\_\_\_\_

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

Postcode \_\_\_\_\_

Daytime contact \_\_\_\_\_

Evening contact / Mobile \_\_\_\_\_

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

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

## ABOUT YOUR PET - Policyholder to complete

Pet's name \_\_\_\_\_

Pet's date of birth \_\_\_\_\_

Pet's Breed \_\_\_\_\_

Pet's colour \_\_\_\_\_

When did you acquire your pet?    /    /

Please tick boxes as appropriate

 Is your pet  Male  Female

 Is your pet a  Cat  Dog

 Has your pet been Neutered / Spayed? (Delete as appropriate) 

 Has your pet been routinely wormed?  Yes  No

 Has your pet been routinely vaccinated?  Yes  No

## DETAILS OF YOUR PET'S CONDITION - Policyholder to complete

What condition(s) are you claiming for?

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

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

For each condition, please tell us the date that 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  Please give date    /    /

 Current Vet name and address \_\_\_\_\_  
 \_\_\_\_\_

Current Vet contact number \_\_\_\_\_

Dates at current Vet From    /    /    to    /    /

Please give details of any other veterinary practices that your pet has been registered at; if you were living at a different address during this time please provide your previous postcode.

 Previous Veterinary name and contact number \_\_\_\_\_  
 \_\_\_\_\_

Dates at Vets From    /    /    to    /    /

 First line of your address and postcode at the time: \_\_\_\_\_  
 \_\_\_\_\_

 Previous Veterinary name and contact number \_\_\_\_\_  
 \_\_\_\_\_

Dates at Vets From    /    /    to    /    /

 First line of your address and postcode at the time: \_\_\_\_\_  
 \_\_\_\_\_

## DETAILS & DECLARATION - Policyholder to complete

I declare, to the best of my knowledge and belief, the information I have given is true and complete. I agree that Animal Friends Insurance Services Ltd may seek any information it requires from any vet.

✗ Sign \_\_\_\_\_ Date    /    /    (Please tick appropriate)

\*Please pay me

\* Please pay my Vet

All payments will be made via direct credit to either your account or your vets. Please contact Animal Friends to provide account details if you are an annual paying customer.

### IMPORTANT NOTES:

FSA number 307858

Animal Friends Insurance Services Ltd administers the policy on behalf of Red Sands Insurance Company (Europe) Limited which underwrite the policy. Animal Friends Insurance Services Ltd is authorised and regulated by the Financial Services Authority (FSA). Animal Friends Insurance Services Ltd Register number is 307858. You can check this on the FSA Register by visiting [www.fsa.gov.uk/register](http://www.fsa.gov.uk/register) or by contacting the FSA on 0845 606 1234

PVC/02/09 FSA

**CASE HISTORY - Vet to complete**

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

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

Name \_\_\_\_\_

Address \_\_\_\_\_

Contact number \_\_\_\_\_

In connection with the treatment being claimed for 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

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

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 / / Results

\_\_\_\_\_

Date / / Results

**CONDITION 1 - Vet to complete**

Date First registered at your practice / /

Date of treatment / /

Diagnosis \_\_\_\_\_

\_\_\_\_\_

Treatment details \_\_\_\_\_

\_\_\_\_\_

If the pet has been seen for a similar or related condition previously please give details

\_\_\_\_\_

\_\_\_\_\_

Have you claimed for this condition for this pet before? Yes No

Total cost of treatment inc VAT £ \_\_\_\_\_

Are euthanasia or cremation costs included in this price? Please quote these prices separately if applicable. £ \_\_\_\_\_

**Please enclose full invoices to support this claim**

**CONDITION 2 - Vet to complete**

Date First registered at your practice / /

Date of treatment / /

Diagnosis \_\_\_\_\_

\_\_\_\_\_

Treatment details \_\_\_\_\_

\_\_\_\_\_

If the pet has been seen for a similar or related condition previously please give details

\_\_\_\_\_

\_\_\_\_\_

Have you claimed for this condition for this pet before? Yes No

Total cost of treatment inc VAT £ \_\_\_\_\_

Are euthanasia or cremation costs included in this price? Please quote these prices separately if applicable. £ \_\_\_\_\_

**Please enclose full invoices to support this claim**

**DECLARATION BY THE VETERINARY PRACTICE - Vet to complete**

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 \_\_\_\_\_

Contact number \_\_\_\_\_

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

✕ Sign \_\_\_\_\_ Date / /

Practice Name and Address (or stamp)

\_\_\_\_\_

Please provide your sort code & account number for payment