



SCOTTISH
PET INSURANCE

Claim Form for Veterinary Fees

For official use only

PLEASE MAKE SURE THIS CLAIM FORM IS COMPLETED CLEARLY AND IN FULL TO ENSURE THE CORRECT ASSESSMENT OF YOUR CLAIM. PLEASE COMPLETE A SEPARATE FORM FOR EACH PET

PLEASE COMPLETE USING A BLACK PEN AND BLOCK CAPITALS

We're happy to help!
If you have any questions call us on
0845 070 1028

1. Policyholder to complete POLICY NUMBER

2. Policyholder to complete ABOUT YOU

Policyholder's address

Policyholder's name

Daytime telephone no

Email 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 date of birth / /

Male Female

Pet's name

Is your pet insured with any other company? Yes No

Pedigree name

If Yes, please state which company

Is your pet a Dog Cat

Breed

4. Policyholder to complete DETAILS OF YOUR PET'S CONDITION

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

What condition(s) are you claiming for?

Date of death / /

Condition 1

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

Condition 2

Name

**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**

Address

Date / / for Condition 1

Postcode

Date / / for Condition 2

Telephone no

Date: from / / to / /

5. Policyholder to complete PAYEE DETAILS

Cheques will be automatically made payable to the policyholder 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

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

Please write the name of the veterinary practice here

Please sign here X

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

B. Pay Policyholder - please tick

I wish the claim to be paid to the policyholder named on the Certificate of Insurance

Please sign here X

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

- The insurance is underwritten and administered by Allianz Insurance plc.
- If the claim form is being faxed, please retain all original copies of the claim form and receipts.
- Please use a separate claim form for each pet.

- Please send completed forms, including copies of all receipts to: Scottish Pet Insurance, Great West House (GW2), Great West Road, Brentford, Middlesex TW8 9DX.

Allianz Insurance plc underwrites the policy. Allianz Insurance plc 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 or by contacting the FSA on 0845 606 1234.

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)

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 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) £ -

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)

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 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) £ -

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 _____

Practice no _____

Email address _____

Vet stamp

Signature  Date / /