

Claim Form for Boarding Fees (Hospitalisation)

PLEASE COMPLETE A SEPARATE FORM FOR EACH PET

N.B. Issue of this form does not constitute admission of liability on the part of the Insurers

Please complete using a black pen and block capitals.

We're happy to help!

If you need any help completing this form, please visit petplan.co.uk/my-petplan/howtoclaim.asp

1. Policyholder to complete	POLICY NUMBER	Reference letters <u>not</u> required							
2. Policyholder to complete	ABOUT YOU	Policyholder's address							
Policyholder's surname									
First name									
Telephone no.		Postcode							
Mobile no.		Please tick here if this is different to the address on your Certificate of Insurance. Your policy records will be updated with these details. <input type="checkbox"/>							
Email address		<small>(Required for electronic payments)</small>							
3. Policyholder to complete	ABOUT YOUR PET	Pet's Microchip no.							
Pet's name		Pet's date of birth		/		/		Male <input type="checkbox"/> Female <input type="checkbox"/>	
Pedigree name		Date you first owned your pet		/		/			
Is your pet a		Dog <input type="checkbox"/>		Cat <input type="checkbox"/>		Rabbit <input type="checkbox"/>			
Breed		Is your pet insured with any other company?		Yes <input type="checkbox"/>		No <input type="checkbox"/>			
If crossbreed, please state dominant breed <small>(dogs only)</small>		If Yes, please state which company							
4. Policyholder to complete	PAYEE DETAILS	Please sign here							
Direct Debit customers		X		Date / /					
<small>Claims payments will be paid into the bank account from which your premium is collected. Please ensure you have given us your email address in Section 2 to avoid delay in settlement.</small>		Print name							
		<small>By signing this form I confirm I have checked the information given and that it is correct to the best of my knowledge. I also give Allianz Insurance plc permission to contact my G.P./hospital physician/surgeon with regards to my condition on this claim form.</small>							
5. Policyholder's general practitioner/hospital physician/surgeon to complete		If all sections are not completed your claim will be delayed							
Patient's name Mr/Mrs/Ms		G.P. practice name and address							
Medical condition requiring hospital treatment		Postcode							
		Telephone no. (incl. STD)							
Date of the first visit to any doctor for this condition		Name and address of admitting hospital							
/ /		Postcode							
Date of hospitalisation from / / to / /		I confirm that to the best of my knowledge the statements are true in every respect.							
Did the patient require convalescence/rehabilitation care outside hospital? Yes <input type="checkbox"/> No <input type="checkbox"/>		Signature(s) of G.P./hospital physician/surgeon (please delete as applicable)		X					
Dates of convalescence from / / to / /		Date / /							
		Print name							
6. Boarding kennel proprietor/home carer to complete		Please attach receipts from licensed kennels/home carer							
Pet looked after by; Licensed kennels <input type="checkbox"/> Receipt attached <input type="checkbox"/>		Date of boarding/home care from / / to / /							
Home carer <input type="checkbox"/> Written confirmation of payment from home carer attached <input type="checkbox"/>		Boarding fees per day		£		-			
Proprietor's name Mr/Mrs/Ms		Total fees		£		-			
Name of kennel/home carer		I confirm that to the best of my knowledge the statements are true in every respect.							
Address		Signature(s) of boarding kennel proprietor/home carer (please delete as applicable)		X					
Postcode		Date / /							
Telephone no. (incl. STD)		Print name							

Important note - Please send completed claim forms including copies of all receipts and vet histories to: **Petplan, Great West House (GW2), Great West Road, Brentford, Middlesex, TW8 9DX.**

INCOMPLETE CLAIM FORMS WILL BE RETURNED TO THE POLICYHOLDER AND THIS WILL DELAY YOUR CLAIM

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