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.

Missing information will delay your claim.

We're happy to help!
If you have any questions call us on
0345 070 3422

1. Policyholder to complete — POLICY NUMBER

2. Policyholder to complete — ABOUT YOU

Policyholder's name

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

Pedigree name

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, plus any information you may have from the person/party you obtained your pet from. Your claim will be delayed if this is not included.

Breed

If crossbreed, please state dominant breed (dogs only)

Pet's Microchip no.

Pet's date of birth / / Male ☐ Female ☐

When did you take on ownership of your pet? / /

4. Policyholder to complete — DETAILS OF YOUR PETS CONDITION

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 (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

By signing this form I authorise Allianz to provide the veterinary practice with information about my policy in respect of this claim and the veterinary practice to provide Allianz with all information relating to my pet. I also confirm I have checked the information given on this form and that it is correct to the best of my knowledge.

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 the vet direct** - please tick
I/We have checked with the vet and would like this claim paid directly to them

Please sign here ✗

Practice name

Date / /

or

☐ **B. Pay policyholder(s)** - please tick
I/We wish the claim to be paid to the policyholder(s) named on the Certificate of Insurance

Print name

IMPORTANT NOTES

- Please include all required documentation, including original invoices and if this is the first claim, a full clinical history
- The insurance is underwritten and administered by Allianz Insurance plc.
- Please use a separate claim form for each pet.
- Please send completed forms, including copies of all receipts to:
  Pet ID Insurance, Great West House (GW2), Great West Road, Brentford, Middlesex TW8 9DX.

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

IF THIS IS THE FIRST CLAIM FOR THIS PET, PLEASE CAN YOU SUBMIT A FULL CLINICAL HISTORY
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?

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

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 / /

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