

## Claim Form

To be completed and returned to: **Homebase Pet Insurance, Freepost - RSTK-ERCB-ZKJT, PO BOX 16283, Birmingham B2 2XJ.**

### A About you (the Policyholder)

If your name or address has changed, please tick

Name, address and postcode

Contact details

Tel Number   
(mobile preferred)

Email

Policy number

Policy Start Date  /  /

Level of Cover

Dog Silver  Dog Gold   
 Dog Platinum  Cat Care  Cat Care Plus

PLEASE NOTE that if any section of the form is not filled in, it may delay your claim – you MUST fill in sections A to E.

Please also read the following notes before submitting any claim and have your policy wording to hand for full details:

Your policy does NOT COVER in whole or as part of a claim:

- Any condition that started before the cover start date
- Any condition that started within the qualifying period of the cover start date
- The excess specified in your policy schedule
- Food
- Flea treatment
- Wormers
- Vaccinations
- Dental treatment unless caused by injury

If this is a claim for a new condition, please ensure the full medical history is attached to the claim form.

### B About your pet

Your pet's name (\* multipet)

\* If you have more than one pet insured with us, please ensure you enter the correct pet's name and only one claim form per pet.

Cat  Dog

Male  Female

Breed

Date of birth  /  /

Has your pet been neutered/spayed? Yes  No

What is the weight of your pet?  kgs

Note: If you are not sure about any of the above information, please ask your vet to complete this for you.

### C About your pet's condition

Name of condition as advised by your vet

Condition 1

Condition 2

Please tell us when you first noticed your pet was unwell or injured, that led you to make an appointment with your vet.

Time & Date

Time & Date

Did you contact our vetfone service? Yes  No

Date:  /  /

Was your pet under your care at the time of the illness/injury/incident? Yes  No

If no, please provide the name and address of any authorised third party looking after your pet at the time of the incident

### D Your previous veterinary practices (Please tell us all vet(s) where your pet was previously registered)

Vet name
Address
Postcode
Phone number
Date: from <input type="text"/> to <input type="text"/>

Vet name
Address
Postcode
Phone number
Date: from <input type="text"/> to <input type="text"/>

Please tell us your address at that time, if it was different to the address in Section A

Postcode

### E Your signature (Policyholder – please complete one of the following boxes (a, b or c) to tell us who to pay)

I declare, to the best of my knowledge and belief, that all the information provided in this form is true and complete. I agree that Homebase Pet Insurance may seek any information it requires from any vet. I accept that the information provided may be released to other companies who provide a service to Homebase Pet Insurance in connection with managing and handling claims

#### a Please pay my claim direct to me:

Printed name:

Policyholder's signature:

Date:  /  /

#### b Please pay my claim direct to my vet:

Printed name:

Policyholder's signature:

Date:  /  /

#### c Please pay my claim direct to the person named below:

Printed name:

Policyholder's signature:

Date:  /  /

**Please note: if we decide we cannot pay some or all of your claim, it is your responsibility to pay your vet**

**F Your vet must fill in this section about each condition** (We only accept claim forms from veterinary practices)

Please advise the date this pet was registered at your practice.

 /  / 

Was this pet referred to a complementary treatment professional?

Yes  No

If Yes, please advise the condition

If this pet was referred to you, please advise the name and address of the registered vet

If Yes, please also complete Sections G & H

Did any condition being claimed result in the death or euthanasia of the pet?

Yes  No

Date of death

 /  / 

If a house call was made, you must confirm in writing why it was absolutely essential

**Condition 1**

What are the main clinical signs?

What is the diagnosis? (This must be completed)

Please tell us the treatment dates for this claim

From  /  /  To  /  /

Have you filled in a claim for this condition before?

Yes  No  Don't know

If yes, treatment dates from the previous claim

From  /  /  To  /  /

**Condition 2**



From  /  /  To  /  /

Yes  No  Don't know

From  /  /  To  /  /

**IF THIS IS A NEW CLAIM, PLEASE COMPLETE THE FOLLOWING QUESTIONS AND FORWARD THE FULL MEDICAL HISTORY.**

**Please tell us the date or the number of days before the first date of treatment, that the clinical signs were first noticed.**

Days  Date  /  /

Days  Date  /  /

Has this pet had this condition or clinical signs before, or any related condition or clinical signs before?

Yes  No

Yes  No

(If 'Yes' we will need the medical history to show the dates and full details)

**G Complementary treatment** (N.B. If the claim involves complementary treatment this section of the claim form must be filled in by a vet and not the complementary treatment professional. Please ensure a copy of the referral letter and invoice(s) are attached.)

What complementary treatment did you refer this pet for?

**If you have not attached a copy of the referral letter or the letter does not contain the following information, please tell us:**

How many sessions have you recommended?

What condition is the complementary treatment for?

Please tell us the cost of complementary treatment

What organisation does the complementary treatment professional belong to? (Please tick)

Association of Chartered Physiotherapists in Animal Therapy

McTimoney Chiropractic Association

National Association of Veterinary Physiotherapists

Canine Hydrotherapy Association

International Association of Animal Therapists

Please explain how this treats the condition.

**H The attending vet or a person authorised by the vet must fill in and sign this section**

Please advise the cost of treatment incl. VAT

**Condition 1**

**Condition 2**

I declare to the best of my knowledge and belief, that all information provided in this claim form is true and complete.

The fees I have charged are no more than the fees I would normally charge my clients.

Veterinary Surgeon's Signature:

Date:

Printed Name:

Email address of the Veterinary Practice:

Practice Stamp

Postcode:

**IMPORTANT: Please ensure that a dated and itemised breakdown of all treatment costs is attached to the claim form before you send it to us. This must state fees for consultation, prescription charge, hospitalisation, X-rays, tests/pathologies, general anaesthetic, surgery, medication and any other fees and costs must be clearly itemised for each condition.**