

## Claim Form for Veterinary Fees

New Condition  Continuation Condition  Previous claim no \_\_\_\_\_

Please make sure this claim form is completed CLEARLY and IN FULL to ensure the correct assessment of your claim.

If you are submitting a CONTINUATION CLAIM, please complete the YELLOW SHADED BOXES MARKED WITH A 'C'. Please complete using BLACK PEN and BLOCK CAPITALS.

Please use a separate claim form for each pet, each illness or injury and each treating Veterinary Practice.

We're happy to help  
If you have any questions call us on  
**0800 255 426**



1. Policyholder to complete POLICY NUMBER: \_\_\_\_\_ C

2. Policyholder to complete ABOUT YOU

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

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

Daytime telephone no. \_\_\_\_\_

Postcode \_\_\_\_\_

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

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 \_\_\_\_\_ C

Breed \_\_\_\_\_

Is this pet insured with any other company? Yes  No

If Yes, Please state which company \_\_\_\_\_

Have you, or are you intending to lodge a claim for this illness/injury with them? Yes  No

Pedigree name  
(if applicable)

Is your pet a Dog  Cat

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

What condition(s) are you claiming for\*? \_\_\_\_\_

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

Date of Death \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please tell us the name & addresses of all vet surgeries where your pet has been treated before or the vet that referred you. (if there is more than one, please use a separate piece of paper)

Name \_\_\_\_\_

Address \_\_\_\_\_

Postcode \_\_\_\_\_

Please tell us the date you noticed any signs that your pet was unwell before booking an appointment with your vet. Your claim may be delayed if you do not give us this information.

Date Condition first noticed \_\_\_\_ / \_\_\_\_ / \_\_\_\_ am pm

Date Pet seen by Vet \_\_\_\_ / \_\_\_\_ / \_\_\_\_ am pm

Telephone no. \_\_\_\_\_

Date: from \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_

If your pet was injured - How did the injury occur (detail on a separate sheet if space is insufficient)

Do you own any other pets NOT insured with Petplan? Yes  No

Is anyone else responsible for the injury, if so supply name & address of person (s)

5. Policyholder to complete PAYEE DETAILS

Payment will be automatically made payable to the policyholder(s) named on your Certificate of Insurance, unless we are instructed otherwise.

Is any insured registered for GST & entitled to an ITC Yes  No

If yes, what is your ITC percentage \_\_\_\_ % ABN \_\_\_\_\_

PLEASE COMPLETE ONE OF THE FOLLOWING

Please note we will not pay your vet unless it has been previously agreed with them to do so. Please check with your vet

A. Pay Vet - please tick (by EFTPOS) C

I/We have arranged with my/our vet and would like this claim paid directly to them, less my excess and any other non claimable items.

Name of the vet practice \_\_\_\_\_

Customer Id \_\_\_\_\_

Account Name \_\_\_\_\_

Account Number \_\_\_\_\_

Vet Practice sign here \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

B. Pay Policyholders(s) - please tick C

I/We wish the claim to be paid to the policyholder(s) named on the certificate of Insurance.

Name \_\_\_\_\_

Account Name \_\_\_\_\_

Account Number \_\_\_\_\_

### INCOMPLETE CLAIM FORMS WILL BE RETURNED TO THE POLICYHOLDER

In order for your claim form to be processed in a timely manner please make sure that you have completed the claim form in full, have your vet complete their section, and it is signed by both You and Your Vet, and includes itemised invoices. If you fax/email your Claim, Petplan still require originals of all faxed/emailed items to be sent in the post.

Are all sections of the claim form completed Yes  No  if not claim form will be returned

Has the Vet completed all their sections of the claim Yes  No  if not claim form will be returned

Have You signed the claim form Yes  No  if not claim form will be returned

Has Your Vet signed the Claim Form Yes  No  if not claim form will be returned

Have included all itemised invoices with Claim Yes  No  if not claim form will be returned

Privacy: The Privacy Act 1993 requires us to tell you that as an insurer we collect your personal and sensitive information in order to calculate your loss and entitlement, determine our liability, compile data and handle claims. When handling claims, we may disclose your personal and other information to third parties such as other insurers, loss adjusters, external claims data collectors, investigators and agents, to the Insurance Reference Service (IRS), etc, or other parties as required by law. You have the right to see access to your personal information and to collect it at any time. Please contact us on 0800 255 426 9am-5pm Mon-Fri and advise us of the changes.

IDR Statement: Disputes are not an everyday occurrence at Petplan. However we do provide an internal dispute resolution process should any dispute arise. Please feel free to ask for details. If you are not satisfied with the outcome of this process, we will advise you how to contact the insurance industry's external independent complaints scheme (subject to eligibility).

I/We certify the information given on this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed. I/We acknowledge that I/We have read and understood the Privacy Act 1993 and consent to the collection, storage, use and disclosure of personal and sensitive information to all persons affected by this claim. I/We acknowledge that if I/We do not agree to the collection of this personal and sensitive information then Petplan will be unable to process my/our claim.

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

Please sign here Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# ASK YOUR VET TO COMPLETE THESE THREE SECTIONS

## 1. 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
/ /	
/ /	

## 2. Vet to Complete

### ABOUT THE ILLNESS OR INJURY

#### Condition

Name of the illness or injury (if no diagnosis has been made please give clinical signs)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is this claim a continuation of a previous claim? Yes  No

When did this illness or injury begin or show clinical signs (as started by the client and noted in 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 being claimed (inc GST) \$ -

PLEASE ENCLOSE FULL ITEMISED INVOICES AND RECEIPTS TO SUPPORT THIS CLAIM ONE CONDITION PER CLAIM FORM

## 3. Vet to Complete

### DECLARATION BY THE VETERINARY PRACTICE

Vet practice stamp here

This practice has authorised to have the claim(s) 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 \_\_\_\_\_

Petplan Practice No: \_\_\_\_\_  
If you do not know - leave blank

Ph: \_\_\_\_\_

Fax: \_\_\_\_\_

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

Signature  Date / /

Vet/Practice Managers