petprotect

Hospitalisation & Boarding Fees Claim Form

Before filling in this form, please:

1. Ensure that all claims are supported by fully itemised receipts or invoices and return to Pet Protect as soon as possible to contact@email.petprotect.co.uk or to the address provided at the bottom of this page.
2. Read your Policy and Certificate of Insurance to check that you are covered.

Policyholder to complete — Your Details

Policyholder Name

Policy Number

Address

Postcode

Name of Pet

Breed of Pet

Pet's Date of Birth D D / M M / Y Y

Mobile Number

Email Address

Policyholder to complete — Bank Details

We will, wherever possible, make payments into the bank account from which your premiums are collected, unless you have provided alternative bank details here.

Name of Account Holder

Name of Bank / Building Society

Account Number

Sort Code – –

Policyholder to complete — Customer Declaration & Authority

- I declare that the statements I have made are true and agree that if they are found to be untrue, I will lose my rights under the policy.
- I authorise Everypaw and any of its representatives to make any enquiries and obtain any information they may consider relevant from me, my doctor, my employer, the Vet, the Referral Vet and/or licensed Credit Reference Agencies who may keep a record of our search.
- I expressly agree that Everypaw and any reinsurers collect and process data concerning my health in the event of a claim, this data being essential to the performance of my policy.
- I understand that I can withdraw my consent at any time. However, the withdrawal of my consent may prevent the processing of my claim and the performance of my policy. In addition the withdrawal of my consent will not terminate my policy or erase the health data collected. I understand that my personal information will be held on computer for the purposes of administering this insurance, including carrying out customer surveys, claims handling and fraud prevention.

Signed (Policyholder)

Name Printed

Date Signed D D / M M / Y Y

Both sides of this claim form must be completed

Making a claim is easy on the Pet Portal
Register on the portal to submit claims and track progress
Visit: petportal.petprotect.co.uk

Return Claim Form to:
Email: contact@email.petprotect.co.uk
Pet Protect, PO Box 7925, Bilston WV1 9TT

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Policyholder to complete — Hospitalisation (Please provide admission & discharge letters)

When were you admitted to hospital?

Dates D D / M M / Y Y

Time (HH:MM) :

When were you discharged from hospital?

Dates D D / M M / Y Y

Time (HH:MM) :

Details of the condition that resulted in your hospitalisation:

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Policyholder to complete — Details of Kennels, Cattery or Home Carer

Did you put your pet into Kennels, a Cattery or arrange for a friend or neighbour to look after your pet?

☐ Kennel ☐ Cattery ☐ Friend or Neighbour

Cost of Boarding Fees (Please attach detailed invoices if applicable)

Per day £

Total £

Dates of Boarding/Home Care

From: D D / M M / Y Y

To: D D / M M / Y Y

Name of Kennel / Cattery / Home Carer

Kennel / Cattery / Home Carer Telephone Number

Kennel / Cattery / Home Carer Address

Policyholder & Hospital to complete — Declaration

To process your claim, we may ask your doctor to provide a medical report about you and we may also ask for copies of your medical records. In order that your doctor can provide this information, we need your signed consent for the release of medical reports and records about you. The Access to Medical Reports Act 1988 also allows you to see medical reports about you before your doctor sends them to us. Please read the following summary of your rights under the Act before giving your consent and indicating if you want to see any medical report(s) about you before they are sent to us.

1. You are not obliged to allow us to see medical reports and records about you, but if you do not, we may not be able to process your claim.
2. We will let you know if we ask for a report, even if you have said that you do not want to see it.
3. If you have indicated that you want to see the report before it is sent, you must contact your doctor within 21 days of us telling you that we have requested it, otherwise your doctor may send it to us.
4. If you have indicated that you do not want to see the report before it is sent, you may still change your mind, but you must contact your doctor before he sends it. You may also ask for a copy of the report for up to six months after it is written.
5. You may ask your doctor to change any part of the report you consider inaccurate or misleading. If your doctor does not agree, you can still include your comments. We may refuse to consider a report containing amendments.
6. Your doctor may withhold any part of the report he considers would harm your health or undermine confidences. However, if the whole report is affected, he cannot send it without your consent.
7. We will provide your doctor with a copy of your authority to enable a report to be produced.

Patient Declaration

I authorise my insurer to obtain any information considered relevant from my doctor, including my medical records for the specific purpose of investigating my insurance claim. Please tick one option:

☐ I **DO NOT** want to see any medical report before it is sent to my insurer.

☐ I **DO** want to see any medical report before it is sent to my insurer.

Signed

Name Printed

Date Signed D D / M M / Y Y

Hospital Declaration

I certify that the patient received medical attention and was confined to hospital during the period specified for the condition detailed above.

Signed by Doctor / Nurse

Position

Name Printed

Date Signed D D / M M / Y Y