Petplan® Petplan® Equine

For Petplan use only

Claim Form for Personal Accident

PLEASE COMPLETE A SEPARATE FORM FOR EACH ANIMAL
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! **0345 074 4408** Horse
If you have any questions call us on **0345 074 4406** Small animal

1. Policyholder to complete — POLICY NUMBER — *Reference letters not required*

2. Policyholder to complete — ABOUT YOU

Policyholder's surname

First name

Email address *(Required for electronic payments)*

Policyholder address

Postcode

Please tick here if this is different to the address on your Certificate of Insurance ☐

Telephone no.

Mobile no.

Payment cheques can be made out to the injured person
If this is not the policyholder please sign as authorisation

Please sign here ✗

Date / /

Print name

3. Policyholder to complete — ABOUT YOUR ANIMAL

Certificate number

Your animal's pet/stable name

Dog ☐ Cat ☐ Horse ☐

Do you own this animal? Yes ☐ No ☐

If **no,** enter the owner's details here

Owner's name

Owner's address

Postcode

Animal's Microchip no.1

Animal's Microchip no. 2

4. Policyholder to complete — ACCIDENT DETAILS

Please give details of the person injured

Mr/Mrs/Ms/Miss Surname Initial

Address

Postcode

Date of birth

Occupation

Date of accident / /

For what purpose was the animal being used at the time the accident occurred?

Please give full details of the injuries

(Please continue on a separate sheet if necessary)

Was the injured person riding, handling or leading the animal? Yes ☐ No ☐

How did the accident happen?

(Please continue on a separate sheet if necessary)

Horses only: Was the injured person wearing an approved riding hat at the time the accident occurred? Yes ☐ No ☐

British Standard number

5. Policyholder to complete — CLAIM DETAILS

Please tell us which benefit you are claiming for (see relevant table of benefits in your policy Terms and Conditions)

For dental claims only, please state the amount you are claiming £ -

Please note: Original invoices should be attached for dental claims

Do you wish to have the cheque(s) made payable to the injured person? Yes ☐ No ☐

Continued overleaf

6. Policyholder to complete — DECLARATION

HAVE YOU ATTACHED ALL NECESSARY ORIGINAL DOCUMENTS?

I/we declare that all the above statements are true in every respect and that I/we have fulfilled the Terms and Conditions of the Policy.

Pay policyholder(s) - please tick one of the options below

☐ **Electronic payment** — If the claimant is the policyholder, ensure you have given us your email address in section 2 and your claim shall be paid into the bank account your premium is collected from.

☐ **Cheque** — If the claimant is not the policyholder, cheques will be made payable to the injured person.

Payment cheques can be made out to the person(s) shown on the certificate. If two people are named, but you have separate bank accounts, please enter below the name to appear on the cheque.

If there are two policy holders shown on the certificate of insurance each one must sign

Your signature ✗ Date / /

Print name

Your signature ✗ Date / /

Print name

I confirm that Petplan may have all reasonable access to my medical records

Signature of the injured person ✗ Date / /

Print name

IMPORTANT NOTES

- Please include all required documentation, including original invoices
- Please use a separate claim form for each animal
- Please send completed claim forms including copies of all receipts to: **Petplan, Great West House (GW2), Great West Road, Brentford, Middlesex TW8 9DX**

INCOMPLETE CLAIM FORMS WILL BE RETURNED TO THE POLICYHOLDER
PLEASE NOW PASS THIS FORM TO YOUR DOCTOR OR DENTIST

7. Medical/Dental practitioner to complete at the policyholders expense — MEDICAL / DENTAL CERTIFICATE

Injured person's name and address

Mr/Mrs/Ms/Miss Surname Initial

Address

Postcode

Are you the insured person's usual medical/dental attendant Yes ☐ No ☐

If yes, for how long have they been registered with you?

When did you first attend the injured person for the injuries? / /

What do you believe to be the cause of the injury?

What is the nature and extent of the injuries sustained?

(a) Please state the area of the body affected (e.g. left/right/upper/lower/limbs/hands/feet/jaw)

(b) Will the injuries give rise to:

(i) Permanent Loss of limb, eye or hearing? Yes ☐ No ☐

(ii) Permanent Total Disability entirely preventing the injured person from any type of work? Yes ☐ No ☐

(iii) Temporary Total Disability preventing the injured person from attending to any part of his/her occupation? Yes ☐ No ☐

(iv) Temporary Partial Disability preventing the injured person from attending to the main part of his/her occupation? Yes ☐ No ☐

(v) The hospitalisation of the injured person? Yes ☐ No ☐

If you have answered YES to the above questions please give full details:

(Please continue on a separate sheet if necessary)

If you have answered YES to questions (iii), (iv), or (v) above please give the dates from which incapacity/hospitalisation commenced and ended,

From / / To / /

Are there any aspects of the injured person's previous medical/dental history which may have a bearing on this claim?

Please state the total cost of the injured person's treatment or estimate if treatment not yet concluded (deleting any treatment cost unrelated to the accident) £ -

Has treatment finished? Yes ☐ No ☐

Medical/Dental Practitioner

Name

Address

Postcode

Date / /

Professional qualifications

Signature ✗ Date / /

Doctors/Dental Practice stamp (if applicable)