

Claim Form for Veterinary Fees and Complementary Treatment

Policy number:

Claim ref:

1a – Policyholder details (to be completed by the policyholder)

Name

Address
Address

Postcode

Home phone no.

Mobile phone no.

E-mail address

1b – Details of your pet (to be completed by the policyholder)

Name

Species

Breed

Date of birth

Date of purchase

2 – Details of your pet's illness or injury (to be completed by the policy holder)

	Illness/injury 1	Illness/injury 2
Name of illness/injury as advised by your vet	<input type="text"/>	<input type="text"/>
Please provide the date you first noticed your pet was injured or unwell	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Veterinary surgeries where your pet has been registered before

Practice name	Practice name	Practice name
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

3 – Policyholder declaration

I declare to the best of my knowledge and belief, the information I have given true and complete.

I agree that NCI may seek any information it requires from any veterinary practice.

A – Direct to you/other payee Your/payee name Signature

Date

B – Direct to your vet Name Signature

Date

4 – Detail of the claim (to be completed by the veterinary practice)

Claim 1

Name of the illness/injury (If no diagnosis had been made please give clinical signs)

Continuation claim (have you previously completed a claim form for this illness/injury)?

Yes No

When did this injury/illness begin?

D	D	M	M	Y	Y
---	---	---	---	---	---

Treatment dates

From

D	D	M	M	Y	Y
---	---	---	---	---	---

to

D	D	M	M	Y	Y
---	---	---	---	---	---

Has the pet been treated for this illness/injury or a similar/related condition before? (If yes please provide a copy of the appropriate clinical history with dates etc.)

Yes No

Were any preventative treatments e.g. Flea/Wormers used as treatment?

Yes No

If yes, please give details

Were you required to make a house visit or provide out of hours treatment?

Yes No

If yes, please explain why the home visit/ out of hours treatment was necessary

Did the illness/injury being claimed for result in the death or euthanasia of the pet?

Yes No

Date of death

D	D	M	M	Y	Y
---	---	---	---	---	---

If the pet was put to sleep was this recommended?

Yes No

Total amount claimed (inclusive of VAT)

£

Claim 2

Yes No

D	D	M	M	Y	Y
---	---	---	---	---	---

From

D	D	M	M	Y	Y
---	---	---	---	---	---

to

D	D	M	M	Y	Y
---	---	---	---	---	---

Yes No

Yes No

Yes No

Yes No

D	D	M	M	Y	Y
---	---	---	---	---	---

Yes No

£

***** For all new claims please include 3 years medical history *****

If this pet has been referred, please give the name, address and telephone number of the practice which referred the pet.

Practice name
Address

Postcode
Tel. no
Date first registered

5 – Veterinary declaration (to be completed by a registered veterinary practitioner/nurse)

I declare that all the information I have given on this claim form is correct to the best of my knowledge and belief.

Name
Position
Signature

Vet Stamp

Date

D	D	M	M	Y	Y
---	---	---	---	---	---

Date

D	D	M	M	Y	Y
---	---	---	---	---	---

Account name
Sort Code

		-			-		
--	--	---	--	--	---	--	--

Account number

--	--	--	--	--	--	--	--