



CLAIM FORM

PLEASE FAX YOUR COMPLETED FORM TO US ON 0330 102 5753 OR EMAIL customerqueries@insurancefactory.co.uk OR POST TO LV=PET INSURANCE, THE CONNECT CENTRE, KINGSTON CRESCENT, PORTSMOUTH, PO2 8QL

Section 1 - This section to be completed by the insured		Policy Number:	
Title:		Cover in force:	
Surname:		Inception Date:	
Forename:		Policy Dates:	
Full Address:		Pet Name	
		Breed:	
		Pet Type:	
Postcode:		Age of Pet:	
Sex of Pet:		Purchase Price:	
Telephone:		Microchip:	
		First date of illness, injury or condition:	
Email Address:			
Please provide a brief description of illness/injury/condition:			
Is your pet currently covered by any other insurance policy? If yes please specify below.			
Name of Insurer:			
Policy Number:		Expiry Date:	
Has your pet been registered with any other vet? If yes, please provide contact details:			
Payment instructions:			
Should we make the payment direct to the Veterinary Clinic?			YES/NO
Where instructions are unclear, payment will be made to you.			<i>Delete as appropriate</i>
Payment to you will be made by BACS (Bankers Automated Clearing Services) if you pay for your policy by Direct Debit and the bank account is in your own name or you are a joint account holder.			
If you do not pay for your policy by monthly Direct Debit and you would like your claim payment to be settled straight into your bank account by BACS (Bankers Automated Clearing Services) please provide the details here.	Account holder name:		
	Sort code:		
	Account number:		
If we pay your claim by BACS a confirmation email will be sent once processed. If we do not hold your email address it will be sent by post.			
Declaration:			
1. I declare that all details provided herein represent a true and accurate statement of the details pertaining to my claim and that I have not omitted any details pertinent to the circumstances of the claim. I can also confirm that this claim form has been signed and dated after the treatment has taken place.			
2. I declare that where a claim involves a potential refund from other insurers or a third party, I hereby authorise them to remit any refund to my insurer.			
3. I understand and agree that information relevant to my claim(s) may be obtained from, and shared with my Vet in order for my claim(s) to be administered.			
4. I understand that in the event that this claim is found to be fraudulent in whole or in part, this will invalidate the policy and may render me liable to prosecution.			
Signed:			
Name:		Date:	
		<i>*Must be after treatment date</i>	





Section 2 - This section to be completed by the Veterinary Surgeon

Age of pet: How long have you been treating the animal?

If this is a referral, please advise of the practice name and address that referred the case:

Date	Diagnosis	Treatment	Cost (inc VAT)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Has the animal received treatment for any of the above, or any related conditions before? **YES/NO**

If yes, please provide details: *Delete as appropriate*

Is this a continuation claim? **YES/NO**
Delete as appropriate

Do you consider this to be a hereditary/congenital condition? **YES/NO**
Delete as appropriate

If a home visit or out of hours treatment took place, was it essential and would the pet's condition have worsened without this happening? **YES/NO**
Delete as appropriate

Has the pet died as a result of the illness/injury mentioned above? **YES/NO**
Delete as appropriate

If the claim payment is a direct settlement to be paid straight into the Surgery bank account by BACS (Bankers Automated Clearing Services) please provide the details here.

Account name:
Sort code:
Account number:

Declaration by Veterinary Surgeon:

Veterinary Practice Stamp and VAT No:

I certify that, to the best of my knowledge all the information contained on this form is correct and that, in my opinion, the condition treated would not have been present upon the date of the inception of the policy. I also confirm that, in my opinion, the fees charged are my normal practice fees relating to this matter.

Signed:

Name:

Date:

A FULL CLINICAL HISTORY AND AN ITEMISED RECEIPT OR ACCOUNT MUST BE ENCLOSED FOR VETERINARY FEE CLAIMS

