

Claim Form

To be completed and returned to: **Argos Pet Insurance, Freepost – RSTK-EEBG-CJYS, PO BOX 16282, Birmingham B2 2XH**
or for a quicker way of submitting your claim to us please email a scanned copy to **claims@argospetinsurance.co.uk**

A About you (the Policyholder)

If your name or address has changed, please tick
Name, address and postcode

Tel Number (mobile preferred)

Email

If you provide us with your mobile number and email address, we can let you know we have received your claim form.

Policy number

Policy Start Date

Level of Cover Silver Gold Platinum

PLEASE NOTE that if any section of the form is not filled in, it may delay your claim – you **MUST** fill in sections A to E. Please also read the following notes before submitting any claim and have your policy wording to hand for full details:
Your policy does **NOT COVER** in whole or as part of a claim:

- Any condition that started before the cover start date
- Any condition that started within the qualifying period of the cover start date
- The excess specified in your policy schedule
- Food
- Flea treatment
- Wormers
- Vaccinations
- Dental treatment unless caused by injury

If this is a claim for a new condition, please ensure the full medical history is attached to the claim form.

B About your pet

Your pet's name (* multipet)

* If you have more than one pet insured with us, please ensure you enter the correct pet's name and only one claim form per pet.

Cat Dog
Male Female

Breed

Date of birth

Has your pet been neutered/spayed? Yes No

What is the weight of your pet? kgs

Note: If you are not sure about any of the above information, please ask your vet to complete this for you.

C About your pet's condition

Name of condition as advised by your vet

Condition 1

Please tell us when you first noticed your pet was unwell or injured, that led you to make an appointment with your vet.

Time & Date

Did you contact our vefone service? Yes No

Was your pet under your care at the time of the illness/injury/incident? Yes No

If no, please provide the name and address of any authorised third party looking after your pet at the time of the incident

If your claim is for an injury, do you believe that another person was at fault? If so, please provide details separately. Yes No

Condition 2

Time & Date

Date

D Your previous veterinary practices (Please tell us all vet(s) where your pet was previously registered)

Practice name
Address

Postcode
Phone number
Date: from _____ to _____

Practice name
Address

Postcode
Phone number
Date: from _____ to _____

Please tell us your name and address at that time, if it was different to the name and address in Section A.

Postcode

E Your signature (Please complete boxes a, b & c to tell us who to pay)

I declare, to the best of my knowledge and belief, that all the information provided in this form is true and complete. I agree that Argos Pet Insurance may seek any information it requires from any vet. I accept that the information provided may be released to other companies who provide a service to Argos Pet Insurance in connection with managing and handling claims.

a Who would you like us to pay:

Policyholder
 Joint policyholder
 Vet/Organisation
 Someone else, named below:
Payee name _____

b How would you like to be paid:

BACS – IMPORTANT: For Policyholders paying by direct debit ONLY.
We will pay any settlement due directly into the account within 3-5 working days.
 Cheque – For joint policy holder, vet, third party or to opt out of BACS payment.

c Your signature:

Policyholder
 Joint policyholder
Signature:
Date:

Please note: if we decide we cannot pay some or all of your claim, it is your responsibility to pay your vet. BACS (Bankers Automated Clearing System) payment option is only available if payment is to be made to the policyholder and if you pay your premium by direct debit.

F Your vet must fill in this section about each condition (We only accept claim forms from veterinary practices)

Please advise the date this pet was registered at your practice.

Was this pet referred to a complementary treatment professional?

Yes No

If Yes, please advise the condition

If this pet was referred to you, please advise the name and address of the registered vet

Postcode

If Yes, please also complete Sections G & H

Did any condition being claimed result in the death or euthanasia of the pet?

Yes No

Date of death

If a house call was made, you must confirm in writing why it was absolutely essential

Condition 1

What are the main clinical signs?

What is the diagnosis? (This must be completed)

Please tell us the treatment dates for this claim

From To

Have you filled in a claim for this condition before?

Yes No Don't know

If yes, treatment dates from the previous claim

From To

Condition 2

From To

Yes No Don't know

From To

IF THIS IS A NEW CLAIM, PLEASE COMPLETE THE FOLLOWING QUESTIONS AND FORWARD THE FULL MEDICAL HISTORY.

Please tell us the date or the number of days before the first date of treatment, that the clinical signs were first noticed.

Days

Date

Days

Date

Has this pet had this condition or clinical signs before, or any related condition or clinical signs before?

Yes No

Yes No

(If 'Yes' we will need the medical history to show the dates and full details)

G Complementary treatment (N.B. If the claim involves complementary treatment this section of the claim form must be filled in by a vet and not the complementary treatment professional. Please ensure a copy of the referral letter and invoice(s) are attached.)

What complementary treatment did you refer this pet for?

What condition is the complementary treatment for?

What organisation does the complementary treatment professional belong to?

Please explain how this treats the condition.

If you have not attached a copy of the referral letter or the letter does not contain the following information, please tell us:

How many sessions have you recommended?

Please tell us the cost of complementary treatment

H The attending vet or a person authorised by the vet must fill in and sign this section

Please advise the cost of treatment incl. VAT

Condition 1

Condition 2

I declare to the best of my knowledge and belief, that all information provided in this claim form is true and complete.

The fees I have charged are no more than the fees I would normally charge my clients.

Veterinary Surgeon's Signature:

Date:

Printed Name:

Email address of the Veterinary Practice:

Practice Stamp

Postcode:

IMPORTANT: Please ensure that a dated and itemised breakdown of all treatment costs is attached to the claim form before you send it to us. This must state fees for consultation, prescription charge, hospitalisation, X-rays, tests/pathologies, general anaesthetic, surgery, medication and any other fees and costs must be clearly itemised for each condition.