

## Claim form

Once you and your vet have completed the form, the quickest way to get it to us is simply email it to the address above with the supporting documents. Alternatively you can send it by post to: John Lewis Pet Insurance Claims, PO Box 1359, Peterborough, PE2 2QU. Our Claims Helpline is 0330 102 2756.

<b>A. About you (the Policyholder)</b> If your name or address has changed, please tick <input type="checkbox"/> (Please note that changes to your address may affect your premium) Your name, address and postcode <div style="border: 1px solid black; height: 100px; width: 100%;"></div> Daytime tel <input type="text"/> Mobile tel <input type="text"/> Email <input type="text"/> <div style="background-color: #c6e0b4; padding: 2px;">Policy number (must be completed)</div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> Please ensure you provide us with your mobile number and email address so that we can keep you informed of the progress of your claim.	<b>IMPORTANT INFORMATION – PLEASE READ</b> Is this claim for a: <input type="checkbox"/> <b>New Condition</b> Please complete all sections <input type="checkbox"/> <b>Continuation Condition</b> Please complete sections A, B & E If this claim is for a new condition please ensure that the pet's full medical history from all the vets that your pet has been registered with is submitted with the claim form. If this claim is for a continuation condition then please ensure that the medical history since the last claimed date of treatment is submitted with the claim form. <b>PLEASE NOTE THAT IF ANY SECTION OF THE CLAIM FORM IS NOT FILLED IN, OR THE SUPPORTING INFORMATION IS NOT SUBMITTED, THIS WILL DELAY YOUR CLAIM.</b> If you are claiming for continuation treatment you must submit claims every 3-6 months. Therefore, in order to save paper, you do not need to submit a claim for every visit to your vet but you can batch the invoices up. Your policy does not cover: <ul style="list-style-type: none"> <li>• Any changes that you or your vet noticed in your pet's health or behaviour before the policy started or any condition that arise from those changes</li> <li>• Any accident that happened within the first 48 hours after the policy start date</li> <li>• Any condition that started within the first 14 days after the policy start date</li> </ul>	<b>B. About your pet</b> Your pet's name <div style="border: 1px solid black; height: 20px; width: 100%;"></div> * 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 <input type="checkbox"/> Dog <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Breed <div style="border: 1px solid black; height: 20px; width: 100%;"></div> Date of birth <input type="text" value="DD/MM/YYYY"/> Your pet's microchip number <div style="border: 1px solid black; height: 20px; width: 100%;"></div> How long have you owned the pet? <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
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<b>C. About your pet's condition</b> Please tell us when you noticed your pet was unwell or injured. If your pet has had the same or similar changes in health we require the first date. A description of the changes to your pet's health that you noted. Did you contact our 24 hour vetfone service for advice on your pet's condition before seeing your vet? Please call <b>0800 3167119</b> if required in the future. Was your pet under your care at the time of the illness/injury/incident? 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 <input type="checkbox"/> No <input type="checkbox"/>	<b>Condition 1</b> Time and Date <input type="text" value="HH:MM DD/MM/YYYY"/> <div style="border: 1px solid black; height: 40px; width: 100%;"></div> Yes <input type="checkbox"/> No <input type="checkbox"/> Date <input type="text" value="DD/MM/YYYY"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<b>Condition 2</b> Time and Date <input type="text" value="HH:MM DD/MM/YYYY"/> <div style="border: 1px solid black; height: 40px; width: 100%;"></div> Yes <input type="checkbox"/> No <input type="checkbox"/> Date <input type="text" value="DD/MM/YYYY"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
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<b>D. Your previous veterinary practices (Please tell us all vet(s) where your pet was previously registered)</b>		
Practice name Address <hr/> Postcode Phone number Date: from <input type="text" value="DD/MM/YYYY"/> to <input type="text" value="DD/MM/YYYY"/>	Practice name Address <hr/> Postcode Phone number Date: from <input type="text" value="DD/MM/YYYY"/> to <input type="text" value="DD/MM/YYYY"/>	Please tell us your name and address at that time, if it was different to the name and address in Section A <div style="border: 1px solid black; height: 40px; width: 100%;"></div> Postcode <input type="text"/>

<b>E. Your Declaration, who to pay and Data Protection notice (Please complete boxes a &amp; b below to tell us who to pay)</b>		
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 <b>John Lewis</b> 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 <b>John Lewis</b> Pet Insurance in connection with managing and handling claims.		
a. YOUR DECLARATION. By ticking the following box, I confirm that I agree with the above statement: <input type="checkbox"/> My name is <input type="text"/> I am the Policyholder: <input type="checkbox"/> I am the Joint policyholder: <input type="checkbox"/> Dated <input type="text" value="DD/MM/YYYY"/>		
b. WHO WOULD YOU LIKE US TO PAY: Policyholder: <input type="checkbox"/> Joint policyholder: <input type="checkbox"/> Vet Practice/Organisation: <input type="checkbox"/>		
c. PAYMENT METHOD: If you pay your premium by Direct Debit we will automatically pay any settlement into that account by electronic transfer. If Direct Debit is not used please ensure that you provide us with your contact details in Section A above, in the event we have to contact you to agree an alternative payment method.		

Please note: if we decide we cannot pay some or all of your claim, it is your responsibility to pay your vet.  
**IF ANY REQUIRED INFORMATION IS NOT RECEIVED THEN THERE WILL BE A DELAY IN PROCESSING THE CLAIM.**

If the condition being claimed for is new please complete all sections and enclose a full medical history for the pet.  
 If the condition is ongoing please complete the sections with the grey box and enclose the medical history since the last claimed date of treatment.

## F. Your vet must fill in this section about each condition

Please advise when the pet was registered at your practice

Date

If this pet was referred to you, please advise the name and address of the registered vet which referred it, and submit the referral letter/report with this claim.

Postcode

If a house call was made, you must confirm below why it was absolutely essential.

If the pet was seen out of hours please confirm why this was and whether the treatment could have waited until normal surgery hours.

What is the diagnosis of the condition (if no diagnosis has been made please provide the main clinical signs)

### Condition 1

Please tell us the treatment dates for this claim

From  To

Is this claim for a continuation of treatment?

Yes  No

If yes, please advise the previous dates of treatment

From  To

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

Yes  No

The body condition score for the pet.

Scale 1-5 (tick to complete)

Scale 1-9 (tick to complete)

If this claim is for a cruciate rupture, is this solely the result of a trauma  or is there any breed predisposition, underlying disease or conformational issue?

Please tell us the date that the clinical signs

were first noticed (as noted on your clinical records). Date

Has this pet had this condition or clinical signs before, Yes  No   
 or any related condition or clinical signs before?

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

Please advise the cost of treatment incl. VAT

### Condition 1

£

### Condition 2

£

## G. The attending vet or a person authorised by the vet must fill in this section

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.

Name:

Position in the Practice:

Practice Address:

Postcode:

Email Address:

Phone Number:

Date:

**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. The costs must be clearly apportioned between each condition being claimed for. Please do not use highlighter pen to apportion costs.**

**IF ANY REQUIRED INFORMATION IS NOT RECEIVED THEN THERE WILL BE A DELAY IN PROCESSING THE CLAIM**