

CLAIM FORM

Please email your completed form to us at swintonpet@insurancefactory.co.uk or post to:
Swinton Pet Claims, 2nd Floor, 5000 Lakeside, North Harbour, Western Road, Portsmouth, PO6 3EN

Section 1 - This section to be completed by the insured		Policy Number																					
Title		Claim ID																					
Surname		Policy dates																					
Forename		Pet name																					
Full Address		Breed																					
		Pet type																					
		Sex of Pet																					
Postcode		Age of Pet																					
Telephone		Purchase Price																					
Email Address																							
		Date of first illness/injury																					
Please provide a brief description of claim:																							
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 <input type="checkbox"/> NO <input type="checkbox"/> (Please cross answer)									
Where instructions are unclear, payment will be made to you.																							
Payment will be made by BACS (Bankers Automated Clearing Services), please provide 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.																							
Have you attached a full medical history (inc. history from any previous practices) as close to birth as possible?														YES <input type="checkbox"/> NO <input type="checkbox"/> (Please cross answer)									
Have you attached an itemised invoice relating to this claim?														YES <input type="checkbox"/> NO <input type="checkbox"/> (Please cross answer)									
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 – 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 practise name and address that referred the case below:			
Start date of treatment (DD/MM/YYYY)	/ /	End date of treatment (DD/MM/YYYY)	/ /
Diagnosis			
Claim cost (inc VAT)		£	.

Start date of treatment (DD/MM/YYYY)	/ /	End date of treatment (DD/MM/YYYY)	/ /
Diagnosis			
Claim cost (inc VAT)		£	.

Start date of treatment (DD/MM/YYYY)	/ /	End date of treatment (DD/MM/YYYY)	/ /
Diagnosis			
Claim cost (inc VAT)		£	.
Has the animal received treatment for any of the above or any related conditions before? If yes, please provide details below		YES <input type="checkbox"/> NO <input type="checkbox"/> (Please cross answer)	
Is this a continuation claim?		YES <input type="checkbox"/> NO <input type="checkbox"/> (Please cross answer)	
Do you consider this to be a hereditary/congenital condition?		YES <input type="checkbox"/> NO <input type="checkbox"/> (Please cross answer)	
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 <input type="checkbox"/> NO <input type="checkbox"/> (Please cross answer)	
Has the pet died as a result of the illness/injury mentioned above?		YES <input type="checkbox"/> NO <input type="checkbox"/> (Please cross answer)	

Declaration by Veterinary Surgeon:							
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 practise fees relating to this matter							
Signed							
Name							
Date (DD/MM/YYYY)							
Veterinary Practise VAT Number							
Veterinary Practise Stamp							
Please use your practice stamp in the box on the right →							