



# Dog and Cat Claim Form for veterinary fees

For Petplan use only

Please note there are items that are not claimable under your Policy, including, but not limited to: routine and preventative healthcare (shampoo, nail clipping, teeth cleaning, worming, desexing and vaccinations), any illness that occurred within your waiting period and/or were a pre-existing condition. If in doubt, please refer to your PDS and Certificate of Insurance. Please also check the excess amount on your policy before completing this form.

## How to make a claim:

**Step 1** Please complete and sign Section 1 of this claim form

**Step 2** Take the claim form to your Vet and ask them to complete Section 2 and sign

**Step 3** Attach the original invoices and receipts to the completed claim form and post, fax or email to:

Petplan Australasia Pty Ltd PO Box 112250, Penrose Auckland 1642 Fax: 09 353 1554 Email: [claims@petplan.co.nz](mailto:claims@petplan.co.nz)

## Section 1. Policyholder to complete

Are you completing this form for a:  New illness or injury or;  Continuation illness or injury

Policy number \_\_\_\_\_ Your Name \_\_\_\_\_

Day phone \_\_\_\_\_ Home phone \_\_\_\_\_ Mobile phone \_\_\_\_\_

Email \_\_\_\_\_

Postal address \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

Address where Pet resides (if different to above) \_\_\_\_\_

Address where loss occurred (if different to above) \_\_\_\_\_

Pet's name \_\_\_\_\_ Pet's date of birth \_\_\_\_\_

Is this pet insured with any other company?  Yes  No If Yes, what is the name of the insurance company \_\_\_\_\_

Have you, or are you intending to lodge a claim for this illness/injury with them?  Yes  No

## Details of your pet's illness

What condition are you claiming for? \_\_\_\_\_

When did you notice the first clinical signs of the condition you are claiming? Date \_\_\_\_\_ Time \_\_\_\_\_ AM/PM

Please tell us the names and addresses of all the vet practices where the pet has attended. \*Please use a separate sheet of paper for more than one.

Practice Name \_\_\_\_\_ Phone \_\_\_\_\_

Treatment date: From \_\_\_\_\_ To \_\_\_\_\_

## Payee details

PLEASE COMPLETE **ONE** OF THE FOLLOWING Please understand that we will not pay your vet unless it has been previously agreed with them to do so.

Please check with your vet prior to selecting your payment option below.

**Pay Vet.** I/We have arranged with my/our vet and would like this claim paid directly to them, less my excess and any other non-claimable items. Name of the vet practice \_\_\_\_\_

or **Pay Policyholder(s).** I/We wish the claim to be paid to the policyholder(s) name on the Certificate of Insurance.

Electronic payment into policyholder's bank account

Account name \_\_\_\_\_ Account number \_\_\_\_\_

## Declaration By Policyholder

I confirm that I am the policyholder and I have checked the information on this claim form and that it is all correct to the best of my knowledge and belief.

Signature   X   \_\_\_\_\_ Date \_\_\_\_\_



## Section 2. Please ask your vet to complete this section

### General information

When was this pet first registered at your practice? \_\_\_\_\_

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

Name \_\_\_\_\_ Phone \_\_\_\_\_

Postal address \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

### About the illness or injury

#### Condition

Name of the illness or injury (if no diagnosis has been made, please give clinical signs) \_\_\_\_\_

\_\_\_\_\_ Treatment date: From \_\_\_\_\_ To \_\_\_\_\_

According to your notes, when did the pet owner first notice clinical signs of the condition?

Date \_\_\_\_\_ Time \_\_\_\_\_ AM/PM

Did **death or euthanasia** result from this illness or injury?  Yes  No Date of death \_\_\_\_\_

If the pet was put to sleep, did you recommend this?  Yes  No Is this claim a continuation of a previous claim?  Yes  No

To your knowledge, has this pet been seen before for:

This illness or injury  Yes  No Any similar or related illness or injury  Yes  No Any similar or related clinical signs  Yes  No

If Yes, please provide the history with dates \_\_\_\_\_ Date \_\_\_\_\_

Total amount being claimed (inc. GST) \$ \_\_\_\_\_

### Declaration By Veterinary Practice

This practice has an Agreement to be paid direct by Petplan  Yes  No

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

Name \_\_\_\_\_ Position in practice \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

Signature 

(Vet practice stamp here)

(To be signed by consulting Vet)

Date \_\_\_\_\_

### What happens next:

Once we receive the necessary documentation, your claim will be processed as quickly and easily as possible. If you have any questions about your claim please call us on 0800 255 426 between 8:30am – 5:00pm Monday to Friday.



We are a member of the Insurance Council of NZ and adhere to the Fair Insurance Code, which provides you with assurance that we have high standards of service to our customers.

