Paycare Claim Form

PRIVATE & CONFIDENTIAL

See overleaf for guidance on how to fill in this form.

A. Policyholder Details

Policy Number:

Forename(s):

Surname: (Mr/Mrs/Miss/Ms)

Date of birth: (DD/MM/YYYY)

Address:

Postcode:

Telephone:

Email:

If your name/address has changed please tell us your previous details:

Please fill in this section if the claim is for your partner (Family Plan only) or dependent child if covered by the Policy

Partner/Child Forename(s):

Partner/Child Surname:

Date of birth: (DD/MM/YYY)

Relationship to you:

B. Receipt Based Claims

Please ensure all relevant/original receipt(s) are enclosed.

Type of treatment(s): Dental: Optical: Chiropody:

Other (please state):

Receipt(s) dated:

Receipt(s) total: £ .

Reason for treatment:

C. Hospital Claims

To be completed by your hospital. Please print in BLOCK CAPITALS

Patient's full name:

Hospital Number:

	Admitted on:	Discharged on:	Home leave:
Day Case			
Inpatient			

Parental Stay (if applicable):

Number of nights:

Name of parent:

Reason for admission/Treatment:

Hospital Stamp:

Signature of authorised official:

Date:

Position of authorised official:

D. New Child Payment

Child's Name:

Date of birth: (DD/MM/YYY)

E. Payment Details

This will enable us to pay your claims directly into your bank account

We only need you to complete this section if it is your first claim or if your bank details have changed

Name of bank:

Sort Code:

Building Society Roll Number (if required):

Account Number:

F. Declaration

I confirm that all the details given on this claim form are, to the best of my knowledge, correct. I authorise you to contact the relevant practitioner, without needing to advise me, to request further information in relation to my claim. I confirm that I cannot recover and/or have not recovered any of the costs I have incurred from any other insurer or any third party.

Policyholder Signature:

Date:

Please return completed form and enclosures to:

Paycare House, George Street, Wolverhampton WV2 4DX

For office use only:

Date received:

Claim Ref:

How to fill in this form

Section A

Make sure you (the policyholder) fill in all your details. If the claim is for your partner or dependent child covered by the policy, add their details in this section too.

Section B *(if you're claiming with a receipt)*

If the claim is for reimbursement of costs paid by you, complete this section and send us the original receipt(s) along with this form. Check your receipt(s) have all the relevant information:

- Name of person receiving the treatment
- Description of treatment/service
- Address of person receiving treatment
- Amount paid
- Name, address & qualification of practitioner
- Date paid
- Date of treatment/service

Section C *(if you've been to hospital)*

If the claim is for Hospital Benefit, ask your hospital to complete all of this section. Or, if all this information is on your original discharge note, you can send us that instead.

Section D *(if you've had a new child)*

Congratulations! Complete all of this section, and send us the original full birth certificate or adoption papers. We'll send these back to you when we've finished.

Section E *(bank details)*

Only fill in this section if you have changed your bank details or if this is your first claim to be paid directly into your bank account.

Section F

Make sure you sign and date your form, and send your form and evidence to us at the address at the bottom of the page.

Don't forget!

You have **13 weeks** to submit your claim from the date you paid for your treatment, or the date you were admitted to hospital.

Warning

If you attempt to make a fraudulent claim we will **cancel your policy** with immediate effect, and may take legal action.

Paycare

Everyday Health Cover since 1874

For full terms and conditions please refer to your Policy booklet or visit our website. If your policy includes Personal Accident cover and you need to claim, please contact us to obtain a special Claim Form.

01902 371 000 www.paycare.org