

6. General information Vet practice to complete

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 and submit the referral letter/report with this claim.

Name _____

Address _____

Postcode _____

Telephone no _____

Was a house visit or out of hours treatment provided? Yes No

If **Yes**, why? _____

Is any part of this claim for a condition the pet can be vaccinated against? Yes No

If **Yes**, were the pet's **vaccinations** up to date at time of treatment?

Yes Date of last vaccination / / No Don't know

Is any part of this claim for **dental treatment**? Yes No

Has this pet had annual dental checks over the last 2 years? Yes No

If **Yes**, you must enclose a full clinical history over the last 2 years. If this is not attached this will delay the client's claim.

Is any part of this claim for treatment of a urinary problem? Yes No

If **Yes**, were crystals/stones present? Yes No

If **Yes**, are the crystals/stones Oxalate? Struvite? Other?

If **other**, please specify

Please give dates of:

1st positive test for crystals

Date / /

1st negative test for crystals

Date / /

7. About the illness or injury Vet practice to complete

Condition 1 **Total amount claimed (inc VAT) £**

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

Is this condition a continuation? Yes No

Treatment dates from: / / to: / /

Did **death** or **euthanasia** result from this illness or injury? Yes No

Date of death / /

When did this illness or injury begin? (as noted on your records) / /

To your knowledge, has this pet been seen before for this illness or injury, any similar or related illness or injury or clinical sign(s)? Yes No

If **Yes**, please provide the history with dates

Date / /

Date / /

Condition 2 **Total amount claimed (inc VAT) £**

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

Is this condition a continuation? Yes No

Treatment dates: from / / to / /

Did **death** or **euthanasia** result from this illness or injury? Yes No

Date of death / /

When did this illness or injury begin? (as noted on your records) / /

To your knowledge, has this pet been seen before for this illness or injury, any similar or related illness or injury or clinical sign(s)? Yes No

If **Yes**, please provide the history with dates

Date / /

Date / /

8. Declaration by the veterinary practice Vet practice to complete

This practice is authorised to have claims paid direct Yes No

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

Name _____ Position in practice _____

Email address _____

Vet stamp

Signature  _____
Date / /

Important Notes

- The insurance is provided by Allianz Insurance plc.
- Please ensure you retain a copy of this claim form and any receipts for your records.

Co-op Insurance is a trading name of CIS General Insurance Limited; registered in England and Wales with registration number 29999R. Registered office: CIS Building, Miller Street, Manchester M60 0AL. CIS General Insurance Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority under register number 435022.

Pet Insurance from Co-op Insurance is provided, underwritten and administered by Allianz Insurance plc. Registered in England and Wales under company number 00084638. Registered Office: 57 Ladymead, Guildford, Surrey GU1 1DB. Allianz Insurance plc is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority under register number 121849. CIS General Insurance Limited is not part of the Allianz (UK) Group.

Incomplete Claim Forms Will Be Returned To The Policyholder