CLAIM FORM FOR VETERINARY FEES

Please Complete in BLOCK CAPITALS	Please complete a separate form for each pet. The completed forms including copies of all receipts should be returned to your agent or broker or direct to our claim handling agency to the following address: IBEX INSURANCE, Apartado de Correos 161, 11311 Guadiaro, Cádiz, Spain **Tel: +34 956695596** If the claim form is being faxed, please retain all original copies of the claim form and receipts. **Fax no: +34 956 794 681**

CLAIM FORMS RECEIVED WHICH ARE INCOMPLETE WILL BE RETURNED TO THE POLICYHOLDER

Policy number:

1. ABOUT YOU (To be completed by the policyholder)	
Policyholder's name	
Policyholder's address and postcode	☐ Please tick if this is different to the address on your certificate of insurance
Telephone No:	
Mobile No:	

2. ABOUT YOUR PET (To be completed by the policyholder)		
Your pet's name		
Pedigree name		
☐ Dog ☐ Cat	☐ M ☐ F	
Did the illness or injury result in the death of your pet? ☐ Yes ☐ No		
Breed		
Date of Birth / /		
Name of each illness or injury you are claiming for, and the date when you first noticed any signs		
1. date / /		
2. date / /		
If your pet has been registered at another practice, other than the current attending practice, during the last 3 years please give details below: (if there is more than 1 please use a separate piece of paper) Vet's Name and Practice Name Address Telephone No. Date: From / / - To / /		
Did the event happen overseas?	☐ Yes ☐ No	**If you have answered Yes**, please provide details about your journey Date: From / / - To / / Countries visited (attach copy of booking invoice or other relevant documents):

3. PAYEE DETAILS (To be completed by the policyholder)

Cheques will automatically be made payable to the Policyholder(s). Please tick 'Other' if you require only one Policyholder to be paid or 'Vet' if you require the Vet to be paid directly.

☐ Vet ☐ Other

Please enter the Payee name and sign below to authorise payment

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4. ABOUT THE ILLNESS OR INJURY (To be completed by the vet practice)

	ILLNESS OR INJURY 1	**ILLNESS OR INJURY 2**
Name of the illness or injury **If no diagnosis has been made please give clinical signs**		
Is this claim a continuation?	□ Yes □ No	□ Yes □ No
When did this illness or injury begin (as noted on your records)?	Date / /	Date / /
Date of Treatment ?	Date / / - Date / /	Date / / - Date / /
Did death or euthanasia result from this illness or injury?	□ Yes □ No	□ Yes □ No
If the pet was put to sleep, did you recommend this?	□ Yes □ No	□ Yes □ No
When was this pet first registered at you practice?	Date / /	
If this pet has been referred please give the name and telephone number of the practice which referred it.	Name Address Telephone number	
To your knowledge has this pet been seen before for:	● This illness or injury ● Any similar related illness or injury or ● Any similar or related clinical signs	□ Yes □ No
	If Yes, please provide the history with dates	Date / / Date / /
Is any part of this claim for dental treatment	□ Yes □ No	**If you have answered Yes**, please enclose a full dental history over the last 2 years
Is any part of this claim for treatment of a urinary problem?	□ Yes □ No	
If Yes: is the cost of diet food included in this claim?	□ Yes □ No	**If Yes,** please provide the name of the diet food being used and total cost being claimed Name Amount €
Where crystals present?	□ Yes □ No	**If Yes,** are the Crystals: □ Oxalate □ Struvite □ Other If other please specify:
Please give dates of last two urine tests	Date / / - Date / /	
Are any of the above conditions of a congenital/ hereditary nature?	□ Yes □ No	
Did death or euthanasia result from this illness or injury?	□ Yes □ No	**If euthanasia did you recommend this?** □ Yes □ No
In connection with treatment claimed did you:	Make a **house visit?** □Yes □ No **or provide** out of hours treatment? □Yes □ No If Yes, why was this house visit/out of hours treatment necessary?	
Total amount claimed (inc. IVA)	Illness or Injury 1 € Please enclose full invoices to support this claim listing dates, treatments and medication.	Illness or Injury 2 € Please enclose full invoices to support this claim listing dates, treatments and medication.

5. DECLARATION BY THE VETERINARY PRACTICE

I have completed this claim form. As far as I know the information is correct. The fees charged are no higher than the normal practice fees.	Name Signature ✘ Date / / Practice No.	Vet Stamp

6. DECLARATION BY THE POLICY HOLDER

Are you happy for Iberian Expatriate to provide the Veterinary Practice identified on this form with information about your policy in respect to this claim?

☐ Yes ☐ No

I declare that the details given are correct to the best of my knowledge and agree that any vet who has treated my pet may provide any information the company may require to process my claim. I confirm that payment is to be made as indicated above.

Signature

✘ Date / /

Signature

✘ Date / /