



Please return the form and any supporting paperwork to:

Pet Claims

**Thistle Insurance Services Limited,
Southgate House, Southgate Street,
Gloucester, GL1 1UB**

If you have any questions please contact
Pet insurance claims department on: **0345 450 7064**

Claim Form for Veterinary Fees

Please make sure this form is completed clearly and in full to ensure the correct assessment of your claim.

Please complete a separate form for each pet.

Please attach receipts for all treatment being claimed.

Please complete using a black pen and BLOCK CAPITALS.

Section 1 About you (to be completed by the policyholder)

Schedule number															
Full name															
Address															
	Postcode														
Email address															
Telephone number								Mobile number							

Section 2 About your pet (to be completed by the policyholder)

Pet's name															
Is this pet a	Dog	<input type="checkbox"/>	Cat	<input type="checkbox"/>	Is this pet	Male	<input type="checkbox"/>	Female	<input type="checkbox"/>						
Breed					Pet's age	Years	<input type="text"/>	Months	<input type="text"/>						
Is your pet insured with any other company?									Yes	<input type="checkbox"/>	No	<input type="checkbox"/>			
If Yes, which company															

Section 3 Details of your pet's illness or injury (to be completed by the policyholder)

What condition(s) are you claiming for and the date you first noticed any signs?																
1.											Date	/	/			
2.											Date	/	/			
Did the condition result in the death of your pet?											Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
Date of death	/	/														

Veterinary surgeries where your pet has been registered or treated in the past two years (if there is more than one, please use a separate piece of paper)															
Name															
Address															
	Postcode														
Telephone number															
Date: from	/	/	to	/	/										

If this is the first claim for an illness please ask your vet to attach a full clinical history for the last two years

Section 4 Declaration (to be completed by the policyholder)

I have checked the information on this claim form (sections 1-3) and confirm that it is all correct to the best of my knowledge and belief.															
Signature											Avid Pet Insurance is administered by Thistle Insurance Services Limited and underwritten by Alpha Insurance A/S. INCOMPLETE CLAIMS FORMS WILL BE RETURNED TO THE POLICYHOLDER				

Your vet needs to complete this page

Section 5 General information

When was this pet first registered at your practice?

Date / /

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

Name

Address

Postcode

Telephone number

In connection with the treatment being claimed did you:

Make a house visit?

Yes ☐

No ☐

Provide out of hours treatment?

Yes ☐

No ☐

If Yes, please clarify why the house visit/out of hours treatment was essential for the health of the pet

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 the time of treatment?

Yes ☐

Please give date of last vaccination

/ /

No ☐

Don't know ☐

Please certify that any prescription diet food is specifically recommended by the manufacturer for the condition treated

Yes ☐

No ☐

N/A ☐

Section 6 About the illness or injury

Condition 1

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

Is this claim a continuation?

Yes ☐ No ☐

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

/ /

Treatment dates:

from

/ /

to

/ /

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 ☐

To your knowledge has this pet been seen 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 / /

Date / /

Total amount claimed (inc VAT)

£ -

Condition 2

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

Is this claim a continuation?

Yes ☐ No ☐

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

/ /

Treatment dates:

from

/ /

to

/ /

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 ☐

To your knowledge has this pet been seen 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 / /

Date / /

Total amount claimed (inc VAT)

£ -

PLEASE ENCLOSE FULL RECEIPTED INVOICES TO SUPPORT THIS CLAIM.

IF THIS IS THE FIRST CLAIM FOR AN ILLNESS PLEASE ATTACH A FULL CLINICAL HISTORY FOR THE LAST TWO YEARS.

Section 7 Veterinary practice declaration

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

Practice name

Position in practice

Email address

Vet stamp

Signature

X

Date / /

INCOMPLETE CLAIMS FORMS WILL BE RETURNED TO THE POLICYHOLDER