

cash plan claim form



To help us process your claim form promptly please complete:-

Section A - All Claimants

Section B - Please ensure you complete part 1 and/or part 2 and sign and date the declaration section.

Section C - If your claim is verified by your company, please ensure they complete this section

Section D - For Maternity or Adoption

Section E - If your claim is Hospital related

Section A - About You

| | | | |
|---|----------------------|----------------------|---------------|
| Full name (enter in box below) | Mr / Mrs / Miss / Ms | Policy No. SP | Date of birth |
| Address | | Telephone | |
| If you have changed your name or address in the last 5 years, please state | | | |
| Previous name | | Previous address | |
| Postcode | | Postcode | |

If the claim is for a dependant child please enter their details below

| | |
|-----------|---------------|
| Full name | Date of birth |
|-----------|---------------|

If the child has a different surname to that of the claimant please attach a copy of their birth certificate which shows the name of the policyholder

Section B Part 1 - Claims with Receipts

Please attach the relevant receipt [or receipts if claiming for more than one treatment] and complete the section below. Please ensure that you send in your completed claim form within 6 months from the first date of treatment. Receipts for dependant children must be in their name and separate to the policyholder. All receipts must be in the name of one person only.

Please tick the box(es) that you wish to claim for and are attaching a receipt(s)

| | | | | | |
|---------------------|-----------|------------------|------------|----------------------------|-------------|
| Optical | Dental | Physiotherapy | Osteopathy | Chiropractic | Acupuncture |
| Podiatry | Chiropody | Hearing Aids | Home Care | Reflexology | Homeopathy |
| Surgical Appliances | | Health Screening | | Hospital Consultation Fees | |

| | |
|-------------------------------------|--------------|
| Total Receipt Amount (in figures) £ | (in words) £ |
|-------------------------------------|--------------|

Section B Part 2 - Claims without Receipts *

Please tick the appropriate box and complete relevant section on reverse of this form.

| | | |
|----------------------|-----------------------------|---------------------------|
| Hospital In- Patient | Hospital Day case Admission | Maternity/Adoption Claims |
|----------------------|-----------------------------|---------------------------|

Declaration

I confirm that the amount(s) shown on the attached receipt(s) are only for those charges incurred by myself or on behalf of my dependant child. I also confirm that the claim made is in accordance with the Terms and Conditions in my Policy Summary. Dental claims are for treatment only and are not for any patient plan, other type of insurance or dental maintenance material such as toothbrushes, mouthwash, floss etc. I understand that benefit is not payable for any ailment or condition (excluding Optical, Dental, Chiropody/Podiatry and Health Screening) arising before acceptance by the company or expiry of the qualifying period. I/We agree that Sovereign Health Care may request medical information from an appropriate medical practitioner or service provider relating to this application or future claims for benefit. I/We agree to be bound by the terms and conditions of the plan.

| | |
|--------|------|
| Signed | Date |
|--------|------|

Section C - Payroll Verification

To be completed and stamped by authorised Company representative

I verify that (full name of employee)

is currently paying the following to Sovereign Health Care through payroll deduction:

| | | |
|-----|---|--------------|
| £/p | Per week/month | Date paid to |
| £/p | Per week/month in respect of an additional person (if applicable) | |

| | | |
|-------------|--------------|------|
| Company No. | Company Name | |
| Signed | Print Name | Date |

Company Stamp

Comments (if applicable)

Section D - Maternity / Adoption Claims

For Maternity / Adoption claims please complete the box below and enclose a copy of the child's full Birth Certificate / Adoption papers

I wish to claim this benefit (please tick)

Number of Birth Certificates / Adoption papers enclosed

Section E - Hospital Claims

To ensure this section is completed correctly please enter your name and date of birth and ask the hospital representative to complete the admission details. Please ask the hospital representative to stamp, sign and date the claim form in the appropriate section.

First name Surname Date of birth

If you are claiming Hospital In-Patient for a dependant child please tick this box and enter their details below

First name Surname Date of birth

Admission details

Hospital Reg. No. Ward No. General Maternity Long stay or Psychiatric

I certify that the above patient was admitted to this hospital for the date(s) and the reason shown below:

Admission duration

Day Surgery

Admitted on

As an in patient

Admitted on

Discharged on

Number of nights

Benefit is not payable for the periods when the patient is allowed out of hospital for any reason (i.e. To work, or leave of absence)

Period 1 from To Period 2 from To

Period 3 from To Period 4 from To

If hospital confinement was a result of a **caesarean section** please sign here

And write the date of the confinement here

Nature of treatment / procedure

Hospital Stamp

Signed

Date

Office use:

Thank you for completing the details as requested. If you have any questions please contact Sovereign Health Care Claims Hotline on 01274 841160