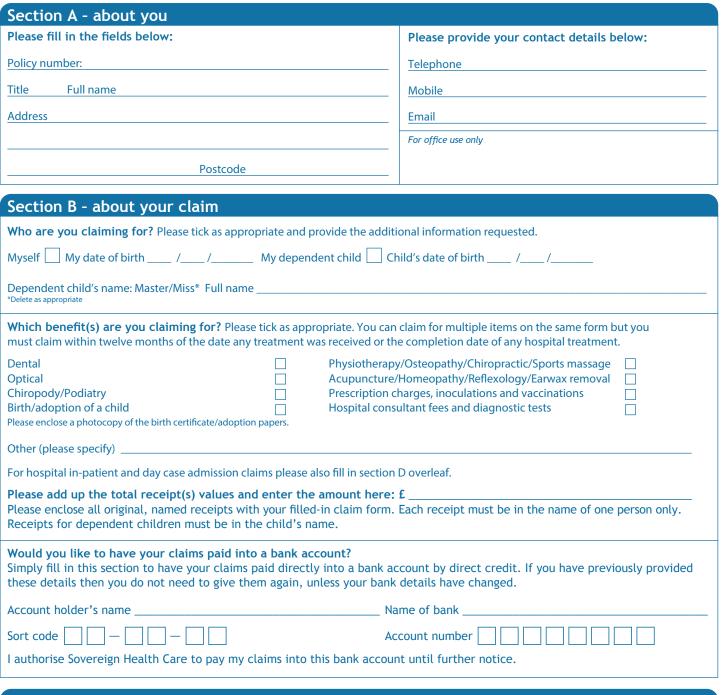
Cash plan claim form

You can use this form to make a claim on your cash plan.

Please refer to your policy terms and conditions to check which benefits you are eligible to claim for.

If you have any questions please contact the Sovereign Health Care customer support team on **01274 841130**. Lines are open Monday to Thursday from 9am to 5pm, and Fridays from 9am to 4pm, or you can email help@sovereignhealthcare.co.uk.



Section C - declaration

I confirm the amount(s) shown on the attached receipt(s) are only for those charges incurred by myself or on behalf of my dependent child. I confirm my dependent child is under the age of 18 and lives with me at the address above. I also confirm my claim is only for treatments covered as detailed in my policy terms and conditions. Occasionally we may ask you, your GP or health care provider or practitioner for a medical report to confirm the details of a claim. By signing this declaration you consent to us doing this. If we do this, we will carry out checks in line with the Access to Medical Reports Act 1988, the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991, the General Data Protection Regulation (EU) 2016/679 and any national laws which relate to the processing of personal data. You must pay any fee your GP or health care provider or practitioner charges for filling in your claim form or providing any further information we ask for. These charges will be your responsibility. We are members of the Insurance Fraud Investigators Group (IFIG) and will share information about suspected fraudulent claims with other members of IFIG. For more details on how we use your personal information and your rights relating to the information we hold about you, please see our privacy policy on our website (or contact us if you would like us to send you a copy).

I consent to Sovereign using the information contained in this claim form and any supporting documentation to process my claim, and to them contacting my GP or health care provider or practitioner to request a medical report where necessary to verify my claim.

Policyholder signature ____

Date _____ /____ /___

Sovereign

Section D - Hospital claims (day case and in-patient admission)

For hospital claims, please fill in this section of the form and provide a copy of your hospital discharge summary with your claim, or ask the hospital or medical centre to fill in this section of the claim form with their details and details of the treatment (they should also sign and stamp the form). If you provide a copy of your hospital discharge summary, this must include the dates of admission and discharge, and the reason you were admitted. Please enter the patient's full name and date of birth:

Patient's full name	Date of birth /
Admission details: Day case In-patient	
Patient's hospital registration number	Ward number General 🗌 Maternity 🗌
Admission duration:	
Day case admitted on / /	
As an in-patient admitted on / and discl	harged on / Number of nights
If maternity admission, please enter baby's date of birth / Benefit is not payable for periods when the patient is allowed out of hospital for any reason (i.e. to work or leave of absence).	
Please provide the dates of any leave of absence below:	It of hospital for any reason (i.e. to work or leave of absence).
Absence 1 from / to / /	Absence 2 from / / to //
I certify that the above patient was admitted to this hospital, on these date(s), for the reason detailed below.	
Nature of treatment/procedure	Hospital/Clinic/Medical Centre stamp
	Signed Date / /
Useful checklist	
Please make sure your receipt(s) details the following:	Sample of receipt

____ The full name of the person who received the treatment

The name and qualifications of the practitioner

Details of the treatment including the date it took place and the cost

Before you post your claim form have you:

Filled in sections A and B?

Signed and dated section C?

Attached relevant named receipt(s)?

If relevant:

For birth/adoption claims, have you enclosed a photocopy of the full birth certificate/adoption papers?

For hospital claims, have you included your hospital discharge summary, or has the hospital, clinic or medical centre filled in, stamped and signed section D?

Next steps: Please return your filled-in claim form and original, named receipt(s) or documents in an envelope to Sovereign Health Care, 2nd Floor, West Wing, The Waterfront, Salts Mill Road, Shipley, Bradford BD17 7EZ. Please remember to use the appropriate postage stamps on the envelope.

For office use only

Sovereign Health Care is a company limited by guarantee. Registered in England no 85588. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Registered office: 2nd Floor, West Wing, The Waterfront, Salts Mill Road, Shipley, Bradford BD17 7EZ.

Chiropody Clinic

123 Anyroad Any Town

BD1 1BB Tel: 01274 000000

Mr A.N Other Dip.Phys

M.C.S.P.S.R.P HCPC Registration Number PH12345

Mrs A Sample, 1 Sample Road Halifax, HX1 1HS

02/01/2024 Treatment £45.00 09/01/2024 Treatment £45.00

Total received with thanks £90.00

10/01/2024