Klapton Cash Back Plan Claim Form

Please verify the information in this document. If you wish to make any corrections or changes, please notify us immediately.

Submitting a Claim Form
Submitting cash back plan claims to us are made via your insurance agent or broker. Please ensure that all relevant sections of this form have been completed and copies of receipts are included. You should retain your original receipts in a safe place. One claim for should be submitted per each benefit claimed and you should send all completed claim forms to us by handing them to your insurance agent or broker. If you have any queries when completing this form then please speak with your insurance agent or broker. Please complete this form in **BLOCK CAPITALS** and use a black pen.

Your Policy Number														
			-			-			-					

Your Broker/Agent Name

The Date of Your Claim							
		-			-		

A. Your Personal Details			
Full Name		**ID Number**	
Address			
Telephone No.		**Mobile No.**	
Date of Birth		**Email**	
Tick Your Plan Level	**O** Silver	**O** Gold	**O** Platinum

B. Your Claim Payment Details
This claim will be paid to you via your insurance agent or broker, whose details are stated herein and in your Schedule.

C. Claim Details		
Please tick the appropriate box for the benefit that you are claiming for, and fill the appropriate section. You should only tick one benefit and you will need to complete a separate form for each claim.		
Benefit Description	**Tick the Appropriate Box**	**Please fill in the following Sections:**
Cash Back Cover – Table of Covered Benefits:		
Dental: Treatment or Dental Injury		D,F,I
Optical		D,I
Hospital in-patient/Day Surgery/Day Care		H,I
Alternative Therapies		D,I
Prescriptions		D,I
Consultations, Diagnostic tests or scans		D,I
Maternity and adoption		E,I
Allergy testing		D,I
Medical Devices		D,I
Flu jabs		D,I
Health assessment/Screening		D,I
Home help		D,I
Funeral grants		D,G,I

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Personal Accident:		
For all types of accidental injuries		Refer to your Insurance Agent or Broker for guidance

D. Receipted Claim			
A copy of the original itemized receipt must accompany all claims and you should ensure that you keep the original in a safe place. Your receipt should bear the name and address of the practitioner alongside the patient treated. Benefits are paid as a percentage of the receipted amount up to your cash back plan's level annual benefit limit.			
Amount Paid		Receipt Date	
Receipt Amount In Words			

E. Maternity and Adoption Claim			
A copy of the original full birth/adoption certificate must accompany the claim and you should ensure that you keep the original in a safe place. The certificate should bear the name and address of the child alongside the parents where applicable.			
Child's Forename		Child Surname	
Child's Date of Birth			

F. Dental Claim			
Claimant Name		Date of Injury	
Cause of Injury			

G. Funeral Grant Claim			
A copy of the original full death certificate must accompany the claim and you should ensure that you keep the original in a safe place. The certificate should bear the name and address of the deceased.			
Name of Claimant		Name of Deceased	
Relationship of Claimant to Deceased			

H. Hospital Admission Claim			
I authorise the hospital to disclose in **Section H** the reason for my admission			
Patient's signature (or signature of legal guardian if patient is under 16): X		Date of Signature:	
To Be Completed By The Hospital			
Full Name of Patient			
Hospital Name			
Signature of Authorizing Officer, Position and Date			
As an In-Patient, admitted on		Discharged on	

Please verify the information in this document. If you wish to make any corrections or changes, please notify us immediately.

Please specify if during the above period the patient was away from hospital for one or more nights			
The Patient was admitted for the following reason (Please tick as appropriate)			
	Accident or casualty admission		Ante/postnatal treatment care for social/domestic reasons
	Convalescence or rehabilitation care		Elective cosmetic surgery
	Geriatric care in-patient for treatment		Corrective eye surgery
	Mental health or psychiatric treatment		In-patient for treatment

Please state the condition for which the patient was admitted		
Was this episode linked to a chronic condition or a pre-existing condition (diagnosed or non-diagnosed) with symptoms experienced within the last 12 months?	Yes	No

Parental Stay			
I confirmed that (name of parent)			stayed overnight with the patient
From		To	

I. Insured's Declaration

I declare that I am not claiming for this claim under other health insurance that I hold (excluding claims for hospital stays, maternity and adoption grants and funeral grants).

I understand that any fraudulent claims may result in legal action being taken and the immediate cancellation of my policy.

I authorise any medical practitioner, or any other person(s) concerned with providing healthcare, to provide Klapton Cash Back Plan with any information that may be relevant to this claim.

If submitting any information on behalf of another person covered by my policy, I also confirm that I am doing so with their knowledge and permission.

I declare the information shown on this form and any accompanying documentation is true and complete.

Insured's Signature		Date	

For Office Use

Claim Received On		Claim Number	

Assessed	
Decided	
Concluded A	
Concluded B	
Concluded C	