

Please complete carefully in **BLOCK CAPITALS** using **black ink**. Please ensure that you complete the claim form in full otherwise it may result in a delay in processing your claim. All claims must be made within 3 months of the date of treatment. Please refer to your plan schedule and the benefits table on the reverse of this form for details of the benefits and excess limits applicable to your plan and level of cover.



1. Plan holder's details

Plan reference* Title* Mr Mrs Miss Ms Other

Forename(s)* Surname*

Address*

 Postcode*

Date of Birth* Email

Telephone no. Mobile no.

Payments to your bank account

All payments will be paid directly into your bank account. Please enter your bank details below.

Bank account number* Branch sort code* Account holders name*

Please complete this section if the claim is for your dependant child

Child's Forename(s) Child's Surname Child's date of birth

Declaration

I hereby declare that the information given by me in relation to this claim is complete and accurate and I give my permission to The Exeter to make any reasonable enquires that it deems necessary to validate this claim.

Signature Date

NB: To protect all plan holders, The Exeter will take action against anyone who makes a dishonest or false claim. Such actions could include, but are not limited to, refusal to accept liability to pay a claim, termination of your plan or legal action.

2. Receipted benefits

Please place a cross against the relevant benefit, and fill in the date and cost of the treatment. You may use this form to claim more than one benefit. Please ensure you enclose all the relevant original receipts with this claim form. If you have received a series of treatments, each receipt must show the date and cost of treatment.

Benefit

Benefit	Amount of receipt	Date
Optical <input type="checkbox"/>	£ <input type="text"/>	<input type="text"/>
Dental <input type="checkbox"/>	£ <input type="text"/>	<input type="text"/>
Complementary Therapies† <input type="checkbox"/>	£ <input type="text"/>	<input type="text"/>
Consultation <input type="checkbox"/>	£ <input type="text"/>	<input type="text"/>
Health Screening <input type="checkbox"/>	£ <input type="text"/>	<input type="text"/>
Counseling <input type="checkbox"/>	£ <input type="text"/>	<input type="text"/>
PMI Excess Cover <input type="checkbox"/>	£ <input type="text"/>	<input type="text"/>
<input type="checkbox"/>	£ <input type="text"/>	<input type="text"/>
<input type="checkbox"/>	£ <input type="text"/>	<input type="text"/>
<input type="checkbox"/>	£ <input type="text"/>	<input type="text"/>



†Physiotherapy, Osteopathy, Chiropractic, Acupuncture and Homeopathy

Remember you will pay the first £30 of the cost in both the dental and optical benefit categories (with the exception of eye tests) in each plan year and any payment we make will be reduced by this amount. The amount you receive will be limited by the maximum annual limits on your plan. We will not pay for any treatment not covered under the terms of the plan. Please refer to 'Your plan explained' booklet for full details of treatments covered by your One Fund Plan. Please note that for claims relating to Complementary Therapies we may ask your practitioner for further information.

3. Receipt requirements

Please note that The Exeter will only pay claims for treatment provided by healthcare professionals who are registered with organisations recognised by The Exeter. See 'Your plan explained' for further details.

When making a claim you will need to send us the original receipt confirming payment.

The receipt must contain certain information, including:

- The full name, address and qualifications of the person providing treatment
- The patient's full name
- A full description of the treatment provided, including dates and amounts paid by the patients

Sample receipt

Name, address and qualifications of practitioner	→	Physiotherapy Clinic HPC REGISTERED 7 ANY PLACE AVENUE, ANYTOWN, AN1 2BG
Details of recipient of treatment	→	MR JOHN SMITH, 11 HIGH STREET, ANYTOWN, A1 2MS
Details of treatment including date, description of treatment and cost	→	03/04/15 FULL DESCRIPTION £18.00 12/04/15 FULL DESCRIPTION £18.00 19/04/15 FULL DESCRIPTION £18.00
Confirmation that the practitioner has been paid for the treatment	→	RECEIPT PAID IN FULL 19/04/15

The Exeter will only accept original receipts. We do not accept receipts which have been altered, nor do we accept invoices, photocopies, credit or debit card payment receipts. Please note receipts will not be returned.

4. Checklist

Please ensure you have:

- Signed and dated the declaration
- Provided your plan number
- Attached all relevant original receipts (including receipts for claims within the excess)
- Completed your bank details

Please return the completed form to The Exeter, Claims Department, Jewry House, Jewry Street. Winchester. Hampshire . SO23 8RZ

If you have a query, please contact us on **0300 123 3256** or email **cashplan@the-exeter.com**
Lines open: Monday – Friday 9am-5pm.

Remember you pay the first £30 of the treatment costs each plan year for the dental and optical benefits only, excluding claims for eye tests. Further claims forms can be requested from customer services on **0300 123 3256** or downloaded from our website **www.the-exeter.com**

Calls may be recorded and monitored.
*This information is mandatory.