The Exeter

You matter more.

Health Cash Plan Claim Form EDS

Please complete this form in full to claim your benefits. All claims must be made within 3 months of the date of treatment. For personal accident claims please request the relevant claim form by calling **0300 123 3256.**

1. Claimant's details

Plan reference* _____

Full Name* (including titles) _____

Address* _____

_____ **Postcode*** _____

Date of Birth* ☐☐ ☐☐ ☐☐☐☐

Email address* _____

Telephone No. _____ **Mobile no.** _____

Contact preference* ☐ Post ☐ Email ☐ Phone

NB: Please note that all payment letters will be sent to you via post.

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

Child's Full Name _____

Child's Date of Birth ☐☐ ☐☐ ☐☐☐☐

Appoint an authorised representative to discuss this claim

If you would like to appoint an authorised representative to speak to The Exeter about this claim, please fill in their details below and include either their date of birth or a password for identification purposes.

Authorised Representative 1

Full name ______________________________

Date of Birth ☐☐ ☐☐ ☐☐☐☐ **Password** ______________________________

Authorised Representative 2

Full name ______________________________

Date of Birth ☐☐ ☐☐ ☐☐☐☐ **Password** ______________________________

2. Details of claim

Please complete the relevant box(es) to show which benefit(s) you are claiming and fill in the amount and the date of the receipt. Please attach all relevant receipts with your claim form. Receipts will be retained for audit purposes.

Optical	Dental	Complementary Therapies*	Amount £	Date of receipt
☐	☐	☐		☐☐ ☐☐ ☐☐☐☐
☐	☐	☐		☐☐ ☐☐ ☐☐☐☐
☐	☐	☐		☐☐ ☐☐ ☐☐☐☐
☐	☐	☐		☐☐ ☐☐ ☐☐☐☐
☐	☐	☐		☐☐ ☐☐ ☐☐☐☐
☐	☐	☐		☐☐ ☐☐ ☐☐☐☐
☐	☐	☐		☐☐ ☐☐ ☐☐☐☐
☐	☐	☐		☐☐ ☐☐ ☐☐☐☐
☐	☐	☐		☐☐ ☐☐ ☐☐☐☐

*For Complementary Therapies you must name the GP who recommended the treatment:

GP Details ______________________________

____

____

3. Payment details

We pay your claim by Direct Credit. If your premiums are funded by someone else (including your employer) or if you would like your claim paid into an account that is different to the one that funds your premiums, please insert your account details below.

We can only pay your claim in to your own or a jointly held bank account.

Account Holder's Name(s)* _____

Bank Account No.* ☐☐☐☐☐☐☐☐

Branch Sort Code* ☐☐☐☐☐☐

4. Declaration

I hereby declare that the information given by me in relation to this claim is complete and accurate. I give my permission to The Exeter to contact the relevant third parties to validate this claim, e.g., dentists, opticians, physiotherapists, etc.

Signature _____

Date ☐☐ ☐☐ ☐☐☐☐

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.

How to claim benefits

This claim form is suitable for claims against our Everyday, Deluxe and Superior Health Cash Plans. Please read in conjunction with your Policy Summary. Benefits are applicable anywhere within the European Community when travelling for business/ pleasure purposes up to 28 days.

PLEASE ATTACH ALL RELEVANT RECEIPTS WITH YOUR COMPLETED CLAIM FORM. ALL CLAIMS MUST BE SUBMITTED WITHIN 3 MONTHS OF RECEIPT DATE, UNLESS STATED OTHERWISE.

We cannot accept liability for any charges incurred in the completion of the claim forms or provision of medical certificates.

Part 1 – Claimant's details

Complete the details of the claimant. If the claimant is a child please add their details at the end of this section.

Part 2 – Details of claim

Select the type of benefit you are claiming for i.e. Optical. See below for the full list of benefits. Then complete the amount and the date of receipt for each benefit claim.

Part 3 – Payment details

All benefits will be paid by Direct Credit. Payments paid by Direct Credit will be paid directly into the bank account you use for your monthly premiums unless you have requested a different account in section 3. Please note we can only pay your claim into an account in your name or a jointly held bank account.

Declaration

Please read and sign the declaration. If we receive your form without a signed Declaration then we will be unable to pay your claim.

Benefit types

Optical

Please send in the completed form with the receipt showing the amount paid and the claimant's name. For optical continuing supply scheme payments please see Benefit Rules in the Policy Summary.

Dental

Please send the completed form with the receipt showing the amount paid in the claimant's name. The receipt must also show the name and address of the Dentist/Dental Practice.

Complementary Therapies – physiotherapy, osteopathy, chiropractic and acupuncture

Please send in the completed form with the receipt showing the amount charged. Please state the name of the GP (General Practitioner) who referred you for treatment. Each visit and amount paid must be shown separately.

Life cover/personal accident/fracture cover

Please contact Customer Services on **0300 123 3256** for a personal accident/fracture cover claim form.

Once you have completed this form please return your completed form to us by post or email:

Post

Send this form and all relevant original receipts to: The Exeter, Claims Department, Jewry House, Jewry Street, Winchester, Hampshire, SO23 8RZ

Email

Send this form and photos in JPEG format or scanned copies in PDF format of all relevant receipts to exeter.cashplan@wessex-group.co.uk

If you have a query, please contact Customer Services on **0300 123 3256.** Lines open Monday – Friday 9am – 5pm.

Calls may be recorded and monitored.

*This information is mandatory.

MKTG157