

# Health Cash Plan Claim Form

## ADT, PHB & MCD

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.

### 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.

<b>Benefit type</b>	Optical <input type="checkbox"/>	Dental <input type="checkbox"/>	Other (please specify) <input type="checkbox"/>	
<b>Amount</b>	£	£	£	
<b>Date of receipt</b>				

Has the complementary benefit been referred by your GP? Yes  No

## 3. Hospital in-patient and day surgery benefit

Please complete only if you are claiming hospital in-patient or day surgery benefit.

Name of the person who received treatment \_\_\_\_\_

Hospital name \_\_\_\_\_

Ward No. \_\_\_\_\_

Details of admission (please tick as appropriate)

General  Maternity  Accident  Day Surgery

Please provide full details \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Stayed in hospital from   to

Was a surgical procedure performed Yes  No

**Please provide a copy of your discharge letter or get this section completed by your hospital**

We hereby certify that the above information is correct.

Speciality \_\_\_\_\_

Unit No. \_\_\_\_\_ Position \_\_\_\_\_

Signature \_\_\_\_\_

Date

**Hospital Stamp**

## 4. 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\***

## 5. 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 Health Cash Plans. Please read in conjunction with your Policy Summary.

PLEASE ATTACH ALL RELEVANT RECEIPTS WITH YOUR COMPLETED CLAIM FORM.

### Part 1 – Claimant's details

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

### Part 2 – Details of claim

Under 'Benefit Type' complete 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.

If not referred by your GP, this may affect your eligibility to claim. Please consult your terms and conditions for further information.

### Part 3 – Hospital in-patient and day surgery benefit

This section must be completed if you are claiming hospital in-patient or day surgery benefit. You must either provide a copy of your discharge letter or have the hospital/day surgery complete the section and certify the details you have provided are correct.

### Part 4 – 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 4. 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

Please read in conjunction with your Policy Summary.

### 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 and the claimant's name. The receipt must also show the name and address of the Dentist/Dental Practice.

### Hospital in-patient and day surgery

Please complete section 3 overleaf to claim under this benefit. A separate claim form must be completed for each hospital in which you or the child were patients.

### Maternity, paternity and adoption

Please send the completed form with your child's FULL original birth certificate showing parents names or adoption papers, which will be returned. Benefit is payable only when the birth or adoption has taken place. This benefit covers the first 9 nights of any hospitalisation related to pregnancy. The hospital certificate must be obtained for any period in excess of 9 nights.

### Health screening

Please submit the completed form with the receipt from the health screening clinic showing the type of screening received and the amount charged.

### Physiotherapy, osteopathy, chiropractic and acupuncture

Please send in the completed form with the receipt showing the amount charged. Each visit and amount paid must be shown separately.

### 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](mailto: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.

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