



A



To be Completed by the Policyholder (All claims must be made within 6 months.)

HSF USE



Forename			
Surname			
Address	Postcode		
Policy No	Telephone Number		
Employer	Email Address		

(If premiums are deducted from pay/pension)

In order to receive settlement of your claim, please provide your bank details below. We can only credit a current account (not a savings account) held in your name.

Account No:	<input type="text"/>	Sort Code:	<input type="text"/>
Account Name:	<input type="text"/>		

This section must be completed in full for all claims (except for dental / optical / chiropody and birth grant) and is also required for every continuing claim. Missing information may delay claim settlement.

PLEASE ANSWER THE FOLLOWING QUESTIONS IN FULL:

1. What diagnosis has been given as the reason for the admission to hospital or for the consultation or for treatment etc.? If no diagnosis has been made, please describe your symptoms:

2. When did symptoms of this condition/problem first begin?

3. When was the family doctor first consulted about them?

B

+ Hospital and Hospice

Patient Forename			
Patient Surname			
Date of Birth	Policyholder	Spouse/Partner	Child under 18

Please tick/select one

TO BE COMPLETED BY THE PATIENT OR GUARDIAN OF CHILD UNDER THE AGE OF 18:

I, the patient or guardian of the named above, was an in-patient at the Hospital/Hospice mentioned below.

Name of Patient/Guardian	<input type="text"/>		
Tick this box to confirm all your details above are correct.		<input type="checkbox"/>	Date <input type="text"/>

Hospital/Hospice	<input type="text"/>		
Address	<input type="text"/>		
Ward	Hospital No. (if known)		
Date of Admission	Date of Discharge		

PLEASE SUBMIT AN ORIGINAL HOSPITAL DISCHARGE SUMMARY TO VERIFY YOUR HOSPITAL STAY. IF YOU ARE UNABLE TO PROVIDE A DISCHARGE SUMMARY WE WILL CONTACT THE HOSPITAL/HOSPICE ON YOUR BEHALF WHICH WILL CAUSE A DELAY IN THE SETTLEMENT OF YOUR CLAIM.

C



Day Case Surgery / Treatment

Patient Forename		Patient Surname	
Date of Birth		Policyholder	
		Spouse/Partner	
		Child under 18	
Hospital			
Ward		Date of Stay	

This benefit is ONLY for planned day case surgery/treatment, NOT for emergency admissions for one day nor for outpatient appointments. Please attach a letter from the hospital confirming your day stay. If this is not available, please print this form and ask the hospital to provide the information in the section below.

TO BE COMPLETED BY THE HOSPITAL

Signature of authorised hospital official confirming day stay and occupancy of a bed.
 Outpatient clinic appointments to be excluded:

Official Hospital Stamp

Designation of above official

Date

D

Other Categories

Receipts enclosed Totalling £ in words

Full name(s) of person(s) to whom the receipt(s) refer(s):

THE RECEIPTS MUST:

- a) be originals, not photocopies; (credit/debit card receipts submitted on their own cannot be accepted)
- b) include the practitioner's stamp/name and date of issue;
- c) include the patient's name;
- d) state the type of service and items provided;
- e) be for a service covered by the HSF categories only and not for any insurance premiums paid to cover that service;
- f) be for a service for which payment has been met by a person registered under HSF health plan.

For a birth or adoption grant claim, you will need to submit/attach the original birth/adoption certificate. If submitting your claim by post, this will be returned to you. If you require a Special/Recorded service please include a self addressed envelope with the correct postage and completed official delivery label.

Receipts will not be returned unless requested.

Should it be necessary for my claim to be verified, I authorise HSF health plan to approach the relevant clinical practitioner/hospital/hospice and authorise them to supply information to enable my claim to be processed.

SIGN / TYPE NAME

Enter your name

Date

Tick this box to confirm all your details above are correct.

Please tick the appropriate box to indicate the nature of the claim(s). HSF USE

1. BIRTH/ADOPTION GRANT	<input type="checkbox"/>
2. SPECIALIST/INVESTIGATIONS	<input type="checkbox"/>
3. DENTAL OPTICAL	<input type="checkbox"/>
4. HOME HELP	<input type="checkbox"/>
5. PHYSIOTHERAPY OSTEOPATHY CHIROPRACTIC ACUPUNCTURE HOMOEOPATHY CHIROPODY/PODIATRY	<input type="checkbox"/>

There are different claim forms for Personal Accident benefits. Please refer to brochure for details of injuries applicable. These include fracture/temporary disability (available on some schemes only) and permanent disability.

If you require one of these forms, please contact our office.
 UK Claims - 020 7202 1381 ROI Claims - 0818 473 473.
 Claims should be made within 6 months.

Checklist

- 1. Have you enclosed your receipts/hospital discharge summary?
- 2. Have you signed the form?
- 3. Have you completed all of the relevant sections?
- 4. Have you completed Pages 1 & 2?
- 5. Have you supplied / checked your bank account details?
- 6. Have you kept a copy of your claim form and receipts submitted for your records?