

CLAIM FORM

Please complete and return with invoices and clinical history:

Post: Kainos International Limited, Pet Claims Dept, The Old Post Office, 1a Penfold Street, Aylsham, NR11 6ET. UK
 or Email: ipet@kainosint.com

Please note that if any section of the form is not completed, it may delay your claim. Please complete one claim form per condition

ABOUT YOU	ABOUT YOUR PET
Your name, address and eircode:	Your Pet's Name:
	CAT/DOG (please delete as necessary)
	MALE/FEMALE (please delete as necessary)
	BREED:
Policy Number:	Dog Licence Number:
Daytime Tel:	Date of Birth / Age:
Evening Tel:	Neutered? YES/NO
	Are you completing this form for a:
Mobile Tel:	New Illness or Injury? YES/NO
	Continuation of existing claim? YES/NO
Email:	Date you first noticed your pet was unwell:
	Name of Illness or Injury as advised by your vet:

YOUR PREVIOUS VETERINARY PRACTICES (please tell us where your pet has previously been registered)		
Vets Name:	Vets Name:	Please tell us your address if it was different to that above:
Address:	Address:	
Tel:	Tel:	

PAYEE DETAILS

I declare that to the best of my knowledge and belief that all the information provided in this form is true and correct. I agree that Kainos International Limited may seek any information it requires from any relevant veterinary practice to aid the assessment of this claim. If we cannot pay some or all of the claim it is your responsibility to pay your vet.

Who would you like us to pay?	Policyholder's Signature:
Veterinary direct: YES/NO Policyholder: YES/NO	Print Name:
BIC:	Date:
IBAN:	

ASK YOUR VET TO COMPLETE THIS PART OF THE CLAIM FORM – IF THIS IS A NEW CLAIM PLEASE SUBMIT A FULL CLINICAL HISTORY

Please advise the date when this pet was first registered to the practice

If this pet was referred, please give the name and address of the referring practice:

Name:

Address:

Was a home visit or out of hours treatment provided? YES/NO

If YES please provide further details:

Did the illness or injury being claimed for result in the death or euthanasia of the pet? YES/NO

If YES please advise the date of the death:

Name of Illness or Injury (if no diagnosis has been made please give clinical signs):

Has the pet had a full Healthcheck in the last 12 months? YES/NO

Please provide treatment dates for this claim

From:

To:

Please tell us the number of days or the date before the first date of treatment that the clinical signs were first noticed

Have you completed a claim form for this Illness or Injury before? YES/NO

Has the pet been seen previously for this Illness or Injury or any similar or related Illness or Injury? YES/NO

If YES please provide further details:

THE ATTENDING VET OR AN AUTHORISED REPRESENTATIVE OF THE VET MUST COMPLETE THIS SECTION

Please advise the cost of the treatment incl. VAT: €

I declare to the best of my knowledge and belief that all the information provided in this claim form is true and complete. I confirm that the fees charged for this treatment are the equivalent of those normally charged by the Veterinary Surgery I represent.

PRINT NAME:

POSITION IN PRACTICE:

SIGNATURE:

DATE:

PRACTICE STAMP:

If a direct payment has been authorised please provide your Veterinary Surgery account details below:

Account Name:

BIC:

IBAN: