



# VETERINARY CLAIM FORM

To return no more than 30 days after the claim date

## Part 1 – To be completed by the Assured

### 1. Policyholder's details

Surname:

First name :

Insurance Certificate n°:

Address :

Telephone n°:

Email :

### 2. Veterinary surgeon's contact details

Usual Veterinary Surgeon's name:

Address:

Telephone n°:

Email :

Has any other vet has attended or seen your horse in your ownership? Yes [  ] No [  ]

Please give details below or on a separate sheet, of any treatment, surgical operation or medication and the name and address of the attending veterinary surgeon.

### 3. Details of Insured Horse

Horse name:

Passport n°

What is your ownership percentage?      %

For what purpose was the animal being used at the time of accident, illness or disease?

In whose charge was the animal at the time of the accident, illness or disease? Name and address if other than Policyholder.

Name:

Address:

Telephone n°:

**Any omission and/or no information about the circumstances may invalidate the claim file.**



#### 4. Details of claim

Give the date, time and location where the animal first became ill or injured:

Date/Time Veterinary Surgeon first advised

Date:

Time:

Date/Time Veterinary Surgeon arrived to attend the animal

Date:

Time:

Please advised the circumstances leading up to the illness/injury:

**Has the treatment for this condition finished?** Yes [  ] No [  ]

**Have you any other insurance for your horse?** Yes [  ] No [  ]

#### 5. Please join this form and healthcare invoices

**6. Do you get back V.A.T ?** Yes [  ] No [  ]

**I declare that all the above statements are true in every respect and that I have fulfilled the terms and Conditions of the Policy:**

**Signature:**

**Date:**



## VETERINARY CLAIM FORM

### Part 2 – To be completed by the Veterinary Surgeon attending the animal in respect of veterinary fee claims

#### Veterinary Surgeon's Certificate

Please complete this form and supply a detailed report of the history, diagnosis, treatment and prognosis of the condition to be claimed on. If the horses has been referred for a second opinion, we require a copy of the original report.

Policyholder details:

Horse name:

Passport n°

Have you attended this horse before? Yes [ ] No [ ]

If YES, please provide full details of any illness, injury or symptoms relevant to current condition.

1. Date of the accident :	
2. Date of onset of the illness or disease:	
3. Is it a chronic disease ?	Yes [ ] No [ ]
4. Symptoms of the current condition:	
5. Date of your first intervention:	
6. Diagnosis of the current illness, disease or injury:	
7. Details of the treatments performed (if several conditions were treated, please indicate if they are related):	
8. Estimated time of treatment:	
9. Is there an alternative treatment? ? If YES, which one ?	
10. *Life and sport prognosis of the current illness, disease or injury *Required	

**I declare that all the above statements are true in every respect**

Signature :

Date :