

Pet Claim Form

Repeat medication

Send your completed claim form to claimform@animalfriends.co.uk.
Alternatively, you can submit your claim through your online account.
If you have any questions, you can call **0344 557 0300**



THIS FORM SHOULD ONLY BE USED TO CLAIM FOR MEDICATION YOU HAVE CLAIMED FOR BEFORE

If it is the first time you have claimed for this medication or you are claiming for any other fees you should use a Vet Fees claim form.

1. ABOUT YOU

Policy number:

Policyholder's name:

Contact number:

Email address:

Policyholder's first line of address:

Policyholder's postcode:

2. ABOUT YOUR PET

Pet's name:

Pet's breed:

Pet's date of birth:

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Male:

Female:

3. ABOUT YOUR PET'S CONDITION(S)

First Condition Name:

Second Condition Name:

Name of Medication(s):

Name of Medication(s):

Total amount claimed (first condition)

 £

Total amount claimed (first condition)

 £

4. ABOUT YOUR CURRENT VET

Please give us the details of the vet that gave you the prescription or medication for your pet.

Vet practice name/branch and phone number:

5. ABOUT PAYING YOUR CLAIM

If we agree to pay your claim, and you pay your premiums by Direct Debit, we will pay any claim payments into that bank account.

If you pay your premium annually, please provide the bank details you would like us to use:

Account holder's name:

Account Number:

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Sort Code:

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6. SENDING US YOUR CLAIM

We aim to process your claim within 2 working days following receipt of all required information.

Please make sure:

- You give us an invoice or receipt with the details and cost of the medication you are claiming for.
- You send us a copy of the prescription your vet gave you.

The completed form and documents should be sent to claimform@animalfriends.co.uk or posted to
Animal Friends House,
1 The Crescent, Sun Rise Way, Amesbury,
Wiltshire, SP4 7QA

7. YOUR DECLARATION

I confirm that the information I have provided on this completed claim form is correct.

I agree that Animal Friends Insurance can talk with any vet, professional or individual that may be involved with this claim.

Please sign here:

Date:

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