



**CLAIM FORM**

**POLICY NUMBER:** \_\_\_\_\_

**POLICY NAME:** \_\_\_\_\_

1-866-275-7387 • www.petcare.ca

**Policyholder Checklist:**

- 1) Make sure Policy Number is filled in.
- 2) Review Policy Documents and Terms and Conditions to see if coverage is available for the current condition being claimed.
- 3) Attach detailed invoices for condition(s) being claimed.
- 4) Complete Claim Form fully - both Part I and Part 2.
- 5) Attach medical history, if not previously submitted.

**Please forward the completed claim form and receipts to:**

PetCare Insurance Brokers Ltd. 710 Dorval Drive, Suite 400 Oakville, Ontario L6K 3V7	Toll Free: 1-866-275-PETS (7387) Fax: 1-866-368-PETS (7387) www.petcare.ca
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**Part I – To be completed by the policyholder** (please print)

Please refer to your Policy Terms and Conditions for the time limitation on submitting claims.

Policyholder: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Please tick if there has been a change of address:

Pet's Name: \_\_\_\_\_ Species: \_\_\_\_\_ Age: \_\_\_\_\_

Sex:  Male  Female Breed: \_\_\_\_\_

To the best of my knowledge, the following statements are true in every respect and I have abided by all of the Policy Terms and Conditions. I understand that any misrepresentation or omission of any material fact can result in denial of the claim.

Signature of Policyholder: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yy)

**Part 2 – To be completed by the Veterinary Clinic ONLY**

Please list the medical Illness/Accident for which the policyholder is making a claim: \_\_\_\_\_

Date accident occurred or symptoms of illness were first noted: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yy)

Has this pet received treatment for this Illness/Accident in the past?  Yes  No If YES, when? : \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yy)

Pet's Weight: \_\_\_\_\_  Kg  Lbs Body Condition Score (BCS): \_\_\_\_\_  1-5 Scale (1 = emaciated, 5 = Obese)  1-9 Scale (1 = emaciated, 9 = Obese)

Was this accident or illness fatal?  Yes  No

If claiming for Accidental Death Benefits, please include a statement from a witness or attending veterinarian and a receipt for the original purchase price of the pet. Please refer to the Policy Terms and Conditions for further details.

Has this pet had an annual physical examination in the past 12 months, and up to date on all recommended vaccinations?  Yes  No

How long has this pet been a client of your clinic?  Less than 18 months  More than 18 months

I confirm that to the best of my knowledge, the above statements are true in every respect.

Signature of Attending Veterinarian: \_\_\_\_\_ D.V.M.

Name of Veterinarian: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yy)

