



Claim Form - QuickCare Policy

Policy # **PT**

Part 1 - To be completed by the policyholder (please print)

Please submit your claim with original **clinic receipts** itemizing fees for all diagnostic tests and treatments. Please refer to your Policy Terms and Conditions for the time limitation on submitting claims.

Policyholder: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Telephone: (____) _____ Fax: (____) _____ Email: _____

Please tick if there has been a change of address:

Pet's Name: _____ Species: _____

Sex: Male Female Age: ____ 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

Please indicate the named accident or illness for which the policyholder is making a claim:

Original QuickCare/QuickCare Plus for Dogs

Fractures: Poison Ingestion:

Lacerations: Burns:

Motor Vehicle Accident:

Foreign Body Ingestion:

Accidental Death:

Allergic Reaction to Insect Bites:

QuickCare Indoor Cats

Burns: Foreign Body Ingestion:

Fractures: Poison Ingestion:

Feline Asthma: Diabetes Mellitus:

Cancer: Infectious Disease:

Feline High-Rise Syndrome:

Bite Wounds/Bite Wound Abscesses:

Feline Lower Urinary Tract Disease:

QuickCare Gold * Please fill in below

Accident: Illness:

QuickCare Plus for Dogs - *Additional Illness Option

Digestive: Ear:

Nervous System: Eye:

Infectious Disease: Cancer:

QuickCare Senior

Laceration: Foreign Body Ingestion:

Burn: Poison Ingestion:

Fracture: Stroke and/or Seizures:

Heart Disease: Boarding Kennel Fees:

Recovery Cost: Trip Cancellation:

Cancer: Euthanasia:

Bite Wound Abscesses:

Motor Vehicle Accident:

Allergic Reaction to Insect Bites:

Accidental Death:

Owner Bequest:

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

Date accident occurred or clinical signs of illness first noted: ____/____/____ (mm/dd/yy)

Has this pet received treatment for this Illness/Accident in the past? Yes No

Was this accident fatal? Yes No

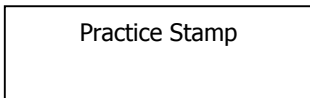
Has this pet had an annual physical examination in the past 12 months, and up to date on all recommended vaccinations? Yes No

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 if Attending Veterinarian: _____ D.V.M. Date: ____/____/____ (mm/dd/yy)

Name of Veterinarian: _____



Please forward completed forms to:
PetCare Insurance Brokers Ltd.
710 Dorval Drive, Suite 400
Oakville, Ontario L6K 3V7

Toll Free: 1-866-275-7387
Fax: 1-866-368-PETS (7387)