My Health Cash Plan

Claim form

To make a claim under your policy, please complete all relevant sections and return the completed and signed form to:

My Health Cash Plan, Customer Services Team, Aviva Health UK Limited, Jewry House, Jewry Street, Winchester, SO23 8RZ.

Before you complete the form please note:

- Your policy may not provide cover for all the benefits listed. Please refer to the terms and conditions booklet and your policy schedule to check your cover before submitting a claim.
- Benefits have a maximum monetary limit each policy year. Please check that you've not already used up all the benefit.

Notes for completion:

- Please use block capitals.
- For all claims sections 1 and 13 must be completed.
- For claims under the Therapies, X-rays and scans and Health Enhance benefits, the relevant section (4, 9 or 11) must be completed by the claimant and section 12 must be completed by their GP.
- For in-patient/day-patient cash benefit and child support cash benefit, please ensure the second part of the section is completed, signed and dated by an authorised representative of the hospital and that an official stamp is used.
- If receipts are required these must be originals and must clearly show the patient's name, provider's name and address, details of treatment and the cost. We do not accept photocopies. We recommend you photocopy your receipt(s) for your records.
- All claims must be submitted within 90 days of the treatment being received.

If you have any queries, please call us on **0800 158 5191** (9am – 5pm Monday to Friday) and one of our advisers will be pleased to help.

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1. Claimants details *Please note this may not necessarily be the policyholder*

Name

Policy number

Address

Date of birth D D / M M / Y Y Y Y

Telephone

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2. Dental benefit *Please attach original itemised receipts*

	Please tick	Amount paid
Dental treatment received		£

Treatment start date D D / M M / Y Y Y Y

Treatment end date D D / M M / Y Y Y Y

Please tick to confirm that you were not aware that this treatment was needed before you joined the policy

3a. Optical benefit

I confirm that I am not claiming from my employer

Signature of claimant (or parent/guardian if claimant is under 16 years old)

Amount paid

If you are claiming for a sight test from your employer please indicate the amount paid by them

£

3b. To be completed by the dispensing optician *(Please attach original itemised receipts)*

Sight test Yes ☐ No ☐

Change in prescription Yes ☐ No ☐

Prescribed glasses (new, not replacement) Yes ☐ No ☐

Prescribed contact lenses (new, not replacement) Yes ☐ No ☐

Prescription date D D / M M / Y Y Y Y

Optician's signature

Name BLOCK CAPITALS

Official stamp of optician

4. Therapies *Please attach original itemised receipts*

Physiotherapy/osteopathy/chiropractic/homeopathy/acupuncture received

Please tick

Amount paid £

Please advise the symptoms and reason for referral by your GP

Date you first experienced symptoms D D / M M / Y Y Y Y

Please complete section 12

5. Prescriptions and GP charges *Please attach original itemised receipts*

	Please tick	Amount paid
NHS prescriptions		£
Inoculations/vaccinations		£
Minor surgery by a GP		£

6. Health screen *Please attach original itemised receipt*

	Please tick	Amount paid
Health screen received		£

7. Baby cash payment *Please attach a copy of the birth / adoption or medical certificate*

Please advise number of children born/adopted ☐

I would like this child/children to be added to the policy and I am aware this may affect my premium Yes ☐ No ☐

8. In-patient and day-patient cash benefit/child support cash benefit

To be completed by the claimant

Please tick

In-patient/day-patient cash benefit ☐

Please tick to confirm that your admission did not relate to a disease, illness or injury that existed before you joined the policy ☐

Child support cash benefit ☐

Name of child admitted to hospital

To be completed by the place of treatment by authorised signatory

I certify that the named patient was an ☐ In-patient ☐ Day-patient ☐ Out-patient

Date of admission D D / M M / Y Y Y Y

Date of discharge D D / M M / Y Y Y Y

Number of nights ☐

Reason admitted, diagnosis and treatment received

Please include a copy of any discharge summary/report

Official stamp of hospital

Signature

Title

Date D D / M M / Y Y Y Y

Hospital reference number

9. X-rays and scans *Please attach original itemised receipts*

Please tick

Amount paid £

X-ray/scan received ☐

Please advise the symptoms and reason for referral by your GP

Please complete section 12

10. Specialist second opinion *Please attach original itemised receipts*

Please tick

Amount paid £

Specialist consultation for a second opinion received ☐

Specialist's name

Type of specialist

Name of specialist seen for initial consultation

Type of specialist

11. Health Enhance *Please attach original itemised receipts*

	Please tick
Chiropody/podiatry/allergy testing/consultation with a dietician received	

Please advise the symptoms and reason for referral by your GP

Please complete section 12

12. Medical details *(for claims under the therapies, X-rays and scans and health enhance benefits)*

To be completed by the GP

Please describe the condition/ symptoms the patient is suffering from

Please state the consultation date when the patient was referred for these symptoms/this condition

D D / M M / Y Y Y Y

How long has the patient been aware of these symptoms / this condition?

I declare that to the best of my knowledge and belief the information given in this medical section is true and complete

Signature of GP

Date D D / M M / Y Y Y Y

Print name

13. Declaration

I declare that to the best of my knowledge and belief the information I have given in this claim form is true and complete.

I am aware that payment will be made into the account from which the premium is paid.

I am aware that the benefit paid will be in line with the terms and conditions of the policy and any benefit limits that apply.

Signature of claimant (or parent/guardian if claimant is under 16 years old)

Date D D / M M / Y Y Y Y

Print name

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