# My Health Cash Plan

## Claim form for groups

AVIVA

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

**My Health Cash Plan, Claims 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 your group member booklet and policy schedule to check your cover before submitting a claim.
- Benefits have a maximum limit each policy year. Please check that you have not already used the benefit up.

## 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.
- 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

Name | Policy number

Address

Date of birth (D D / M M / Y Y Y Y) | Telephone

**Reimbursements** These will be paid directly into your bank account. Please provide the details of the account you would like us to pay the money in to.

Account number | Sort code

Name(s) of account holder(s)

Name of bank or building society

If you would like us to confirm payment by email, please enter your email address

## 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

## 3. Optical benefit *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.*

| | Please tick | Amount paid |
|---|---|---|
| Physiotherapy / osteopathy / chiropractic / homeopathy / acupuncture received | | £ |

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 bonus *Please attach a copy of the birth / adoption certificate*

Please advise number of children born / adopted

## 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**

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 and treatment received

Official stamp of hospital

Signature

Title

Date D D / M M / Y Y Y Y

Hospital reference number

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## 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**

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## 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**

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## 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

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## 13. Declaration

**Please do not forget to complete your account details in section 1 so that we can reimburse you without delay.**

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 I have detailed in section 1 of this form.

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.

I consent to the:

- processing (by computer or otherwise);
- use (which may happen outside the European Economic Area) for the purpose of claims assessment and validation, fraud prevention, policy administration and service provision; and
- disclosure to the policyholder, relevant intermediaries and medical service providers of personal and medical details supplied in support of this claim.

The data controllers are Aviva Health UK Limited, Aviva Insurance Limited, Aviva Life & Pensions UK Limited and Wessex Administration Services Limited.

I agree that a copy of this consent shall have the validity of the original.

Signature of claimant

Date D D / M M / Y Y Y Y

Print name

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