Moo Pet Insurance Claim Form

Please complete and scan with invoices, photograph, vaccination card and all clinical history to email address: claims.moopet@kainosint.com.

Please note that if any section of the form is not completed, it may delay your claim. Please complete one claim per condition.

ABOUT YOU	ABOUT YOUR PET
Policy Number:	**Pet's Name:**
Email:	**Is your Pet a: Cat / Dog** **Are they : Male / Female**
Your name, address:	**Date of Birth / Age:**
	Breed:
	Neutered? YES/NO
	Licence/Tag Number:
	Date issued:
Name of Illness or Injury as advised by your vet:	**<u>Are you completing this form for a</u>:** **New Illness or Injury? YES/NO** **Continuation of existing claim? YES/NO**
Date you noticed your pet was unwell:	

YOUR PREVIOUS VETERINARY PRACTICES (please tell us where your pet has previously been registered)	
Vets Name:	**Vets Name:**
Address:	**Address:**
Email:	**Email:**
You are responsible for contacting any previous veterinary practices and supplying any previous history.	

PAYEE DETAILS	
I declare that to the best of my knowledge and belief all the information provided in this form is true and correct. I agree that Kainos International Ltd may seek any information it requires to aid the assessment of this claim. I understand that any deductible or co-payment will be deducted, and if you cannot pay some or all of the claim, it is my responsibility to pay my vet.	
Who would you like us to pay? **Veterinary direct: YES/NO Policyholder: YES/NO**	**Policyholder's Signature:**
	Print Name:
BIC:	
IBAN:	**Date:**

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ASK YOUR VET TO COMPLETE THIS PART OF THE CLAIM FORM (If this is a new claim, please submit a full clinical history)

Please advise the date when this pet was first registered to the practice	
If this pet was referred, please give the name and address of the referring practice: **Name:** **Address:**	
Was a home visit or out of hours treatment provided? YES/NO **If YES, please provide further details:**	
Did the Illness or Injury being claimed for result in the death or euthanasia of the pet? YES/NO **If YES, please advise the date of the death:**	
Name of Illness or Injury (if no diagnosis has been made, please give clinical signs):	
Has the pet had a Healthcheck in the last 12 months? YES/NO	
Please provide treatment dates for this claim **From:** **To:**	
Please tell us the number of days, or the date, before the first date of treatment that the clinical signs were first noticed:	
Have you completed a claim form for this Illness or Injury before? YES/NO	
Has the pet been seen previously for this Illness or Injury or any similar or related Illness or Injury? YES/NO **If YES, please provide further details:**	
Please attach the following to the claim form: **1) A clear photograph of the pet you have treated.** **2) Full clinical history for the pet and invoices for the incident.**	

THE ATTENDING VET OR AN AUTHORISED REPRESENTATIVE OF THE VET MUST COMPLETE THIS SECTION	
Please advise the cost of the treatment:	
I declare to the best of my knowledge and belief that all the information provided in this claim form is true and complete. I confirm that the fees charged for this treatment are the equivalent of those normally charged by the Veterinary Surgery I represent.	
PRINT NAME:	**LICENCE NUMBER:**
SIGNATURE:	**DATE:** **Practice Stamp**

If a direct payment has been authorised, please provide the Veterinary Surgery account details below:		
Account Name:	**BIC:**	**IBAN:**