OneFamily

Health Cash Plan Claim Form
(For policies taken out June 2010 onwards)

Please complete this form in full to claim your benefits.
For personal accident or life cover claims please request the relevant claim form by calling **0800 988 2129.***

1. Claimant's details

Please complete your details in black ink using BLOCK CAPITALS.

Membership No.

Title Mr Mrs Ms Miss

Surname

Forename(s)

Address

Postcode

Email

Date of birth D D M M Y Y Y Y

Tel. no. day

Tel. no. eve

If you are claiming on behalf of a child please complete this section

Child surname

Child forname(s)

Child Date of birth D D M M Y Y Y Y

2. Details of claim

Please complete the relevant box(es) to show which benefit(s) you are claiming and fill in the amount and the date of a receipt.
Please attach all relevant original receipts with your claim form. Receipts will be retained for audit purposes.

Optical	Dental	Complementary Therapies	Amount £	Date of receipt
				D D M M Y Y Y Y
				D D M M Y Y Y Y
				D D M M Y Y Y Y
				D D M M Y Y Y Y
				D D M M Y Y Y Y

For Complementary Therapies you must name the GP who recommended the treatment.

3. Payment details

We pay your claim by Direct Credit. If your premiums are funded by someone else (including your employer) or if you would like your claim paid into an account that is different to the one that funds your premiums, please insert your bank/building society account details below.
We can only pay your claim in to your own or a jointly held bank account.

Name(s) of account holder(s)

Branch sort code — —

Bank/building society account number

Declaration

I wish to make a claim for the benefit(s) stated and confirm I am eligible to claim.

Signature ✘

Date D D M M Y Y Y Y

How to claim benefits

This claim form is suitable for claims against our Everyday, Deluxe and Superior Health Cash Plans. Please read in conjunction with your Policy Summary. Benefits are applicable anywhere within the European Community when travelling for business/pleasure purposes up to 28 days.

PLEASE ATTACH ALL RELEVANT ORIGINAL RECEIPTS WITH YOUR COMPLETED CLAIM FORM. ALL CLAIMS MUST BE SUBMITTED WITHIN 3 MONTHS OF RECEIPT DATE, UNLESS STATED OTHERWISE.

We cannot accept liability for any charges incurred in the completion of claim forms or provision of medical certificates.

Part 1 – Claimant's details

Complete the details of the claimant. If the claimant is a child please add their details at the end of this section.

Part 2 – Details of claim

Under 'Benefit Type' complete the type of benefit you are claiming for i.e. Optical. See below for the full list of benefits. Then complete the amount and the date of receipt for each benefit claim.

Part 3 – Payment details

All benefits will be paid by Direct Credit.

Payments paid by Direct Credit will be paid directly into the bank account you use for your monthly premiums unless you have requested a different account in section 3. Please note we can only pay your claim into an account in your name or a jointly held bank account.

Declaration

Please read and sign the declaration. If we receive your form without a signed Declaration then we will be unable to pay your claim.

Benefit types

Optical

Please send in the completed claim form with the **original** receipt showing the amount paid and the claimant's name. For optical continuing supply scheme payments please see B enefit Rules in the Policy Summary.

Dental

Please send in the completed claim form with the **original** receipt showing the amount paid and the claimant's name. The receipt must also show the name and address of the Dentist/Dental Practice.

Complementary Therapies – physiotherapy, osteopathy, chiropractic and acupuncture

Please send in the completed claim form with the **original** receipt showing the amount charged. Please state the name of the GP (General Practitioner) who referred you for treatment. Each visit and amount paid must be shown separately.

Life cover/personal accident cover/fracture cover

Please contact Customer Services on **0800 988 2129*** for a life cover/personal accident/fracture cover claim form.

Once you have completed the claim form, please return it with the required supporting information to:
OneFamily Health, Claims Department, Hornbeam Park Avenue, Harrogate HG2 8XE

*We might record your call to help improve our training and for security purposes. We hope you don't mind. Calls are only free from UK landlines.
Lines open: Monday – Friday 9am-7pm, Saturday 9am-1pm.

OneFamily, Hornbeam Park Avenue, Harrogate, HG2 8XE tel; 01423 855000 fax; 01423 855181.