UK Healthcare™

Health Cash Plan claim form

Please complete in black ink using block capitals otherwise claims may be delayed.

Person receiving treatment (policyholder or partner)

Title Surname

First name(s)

Policy number Contact number

Date of birth D D M M Y Y Y Y

Address

Postcode

Email

Claim

Treatment claimed for

Amount of receipt £ .

Dependent child receiving treatment

Title Surname

First name(s)

Date of birth D D M M Y Y Y Y

Payments

Account name

Sort code Account number

Declaration and Access to Medical Reports Act 1988

I declare that the above information is correct. I understand that fraudulent claims will result in legal action and cancellation of my membership. I hereby authorise the relevant medical practitioner to divulge any information relating to the above claim.

Please tick Signature Date D D M M Y Y Y Y

Checklist!

✓ Have you ticked the declaration? ✓ Is this claim within 3 months of the date of treatment?

✓ Are appropriate receipts (plus debit/credit card receipts) attached?

RETURN TO: UK Healthcare, PO Box Bolton, PO Box 335, S98 1BY