

TO BE COMPLETED USING BLOCK LETTERS

Please refer to your membership plan when claiming benefits and make sure you complete your member number as your claim could be delayed

For office use only:



1. Member's personal details

Member number

You can visit our website www.healthshield.co.uk and use your member number to register on our Members' Area where you can check your benefit allowances and submit your receipt based claims online.

Home address

Title

Post code

Surname

Telephone number

Forename(s)

Personal email

Date of birth DD MM YY Gender Male Female

I want to be paperless, please send all my Health Shield membership information by email.

2. Your claim

Please ensure that you enclose all the relevant, original receipts with this claim form. If you have had a series of treatments the receipt must show the date and cost for each treatment. Please also refer to the 'How to Claim' section on our website for full receipt details. If claiming for a private medical insurance (PMI) excess fee please also refer to Section 4.

I am claiming for:

| Forename | You | Partner | Child | Date of birth | Benefit | Amount paid | Treatment date | Medical reason for treatment |
|----------------------|--------------------------|--------------------------|--------------------------|---|----------------------|------------------------|---|------------------------------|
| <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> DD <input type="text"/> MM <input type="text"/> YY | <input type="text"/> | £ <input type="text"/> | <input type="text"/> DD <input type="text"/> MM <input type="text"/> YY | <input type="text"/> |
| <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> DD <input type="text"/> MM <input type="text"/> YY | <input type="text"/> | £ <input type="text"/> | <input type="text"/> DD <input type="text"/> MM <input type="text"/> YY | <input type="text"/> |
| <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> DD <input type="text"/> MM <input type="text"/> YY | <input type="text"/> | £ <input type="text"/> | <input type="text"/> DD <input type="text"/> MM <input type="text"/> YY | <input type="text"/> |
| <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> DD <input type="text"/> MM <input type="text"/> YY | <input type="text"/> | £ <input type="text"/> | <input type="text"/> DD <input type="text"/> MM <input type="text"/> YY | <input type="text"/> |

For hospital and maternity claims please see the reverse of this form.

Please indicate here if you are claiming for these benefits: Yes No

3. Benefit payment direct to your bank account

Please enter your personal bank details below. We are unable to pay third party bank accounts or credit card accounts. If you have already provided these details then there is no need to fill them in again unless your account details have altered, or we hold more than one account on your policy. We no longer pay benefit by cheque. If this is a problem then please contact us on **01270 588555**.

| Bank/Building society name | Account number | Sort code |
|----------------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

4. Private medical insurance (PMI) excess fees

Before making a claim please refer to your membership plan to ensure that excess fees are covered under your policy.

If this is to be paid directly to your provider please enter their details below (if these details are not clear or not completed fully the payment will be made to you).

Make cheque payable to

Provider address

Please enclose a copy of your PMI claim statement from your PMI insurer to support this claim and please make sure you have also completed Section 2 above.

5. Member's authorisation and signature

I declare that all the information included is accurate, true and complete to the best of my knowledge and belief.

I agree that Health Shield can confirm the details with the healthcare provider.

I understand that Health Shield may end my membership if my claim is found to be fraudulent.*

Your signature Date DD MM YY

*Fraudulent claims – Health Shield are committed to preventing financial crime and we will report to the police all instances of fraud or attempted fraud.



6. Hospital claims

The member must fill in Section 6. This must then be checked, signed and stamped at the hospital, registered treatment centre or hospice. Alternatively, please enclose proof of your hospital stay by sending your discharge letter or discharge summary. Please make sure all of the information required below is printed on your discharge papers. Please allow a minimum of 2 to 3 weeks when claiming these benefits.

Title (please circle) Mr, Mrs, Miss, Other Name of hospital

Patient's surname

Patient's forename(s) Patient's hospital number (if known)

| | | | | |
|--|--|--|--|--|
| The patient was admitted for the following treatment (4 tick as applicable) | | | Parental stay | |
| <input type="checkbox"/> Inpatient | <input type="checkbox"/> Day-surgery patient | <input type="checkbox"/> Given anaesthetic or sedation | Name of parent accompanying child overnight <input type="text"/> | |
| <input type="checkbox"/> Maternity related | <input type="checkbox"/> Elderly care | <input type="checkbox"/> Respite care | No. of nights <input type="text"/> | Dates: From <input type="text"/> <input type="text"/> <input type="text"/> To <input type="text"/> <input type="text"/> <input type="text"/> |

| | | | | | |
|--------------------------|----------------------|----------------------|----------------------|--|--|
| Admissions | | | | Has the patient been home on leave? | |
| Date admitted | Date discharged | No. of days | No. of nights | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | If 'Yes' please state dates <input type="text"/> | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | Has the patient previously been admitted for this condition? | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Medical condition | | | | | |
| <input type="text"/> | | | | | |

I certify that the patient was admitted on these dates for the following medical condition(s) detailed above.

Official stamp of hospital, registered centre or hospice

Position of authorised official

Signature of authorised official

Date The form must be signed and dated on or after the date of discharge

7. For maternity – antenatal appointment and adoption claims only

Date of scan

Number of weeks pregnant at scan date

Patient's name

Signature of authorised official

Official stamp of GP surgery or hospital

Please return to

Please return this form along with all the necessary additional information and receipts to Health Shield. We aim to turnaround all receipt-based claims within two working days. Please note, the return Health Shield address below is positioned for a standard window envelope, if you wish to use one.

Health Shield Friendly Society Ltd
Electra Way, Crewe Business Park
Crewe, Cheshire
CW1 6HS

Claims checklist

- Have you signed and dated Section 5?
- Have you included your membership number?
- Have you completed Sections 2 and 3?
- Have you attached the relevant receipts, certificates or papers?
- If relevant, has the hospital checked, stamped and signed Section 6, on or after the date of discharge?
- If relevant, have you checked that all of the information required in Section 6 is printed on your discharge papers?
- Is your treatment date less than 12 months ago?
- Have you read the terms & conditions relevant to the benefit you are claiming?

Health Shield Friendly Society Ltd.

Electra Way, Crewe Business Park, Crewe, Cheshire, CW1 6HS.
01270 588555 | Opening hours: 9.00am to 5.00pm, Mon to Fri.
www.healthshield.co.uk

Established in 1877. Health Shield Friendly Society Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. As part of our on-going quality control programme, calls may be monitored or recorded.