

Claim Form for Personal Accident

N.B. Issue of this form does not constitute admission of liability on the part of the Insurers
 Please send completed claim forms to: equine-claims@allianz.co.uk or Petplan Equine,
 PO Box 222, Huddersfield, HD8 1FQ.

We're happy to help! 0345 074 2676

1. Policyholder to complete

POLICY NUMBER

Reference letters *not* required

2. Policyholder to complete

ABOUT YOU

Policyholder surname

First name

Policyholder address

Postcode

Telephone no.

Mobile no.

Email address

(Required for electronic payments)

Please tick here if this is different to the address on your Certificate of Insurance

3. Policyholder to complete

ABOUT YOUR HORSE

Your horse's name

Do you own or have this horse on full loan? Yes No

If **no**, enter the owner's details here

Owner's name

Owner's address

Postcode

4. Policyholder to complete

ACCIDENT DETAILS

Please give details of the person injured

Mr/Mrs/Ms/Miss

Surname

Initial

Address

Postcode

Date of birth

Occupation

Date of accident / /

For what purpose was the horse being used at the time the accident occurred?

Please give full details of the injuries

Was the injured person riding, handling or leading the horse? Yes No

How did the accident happen?

Was the injured person wearing an approved riding hat at the time the accident occurred? Yes No

British Standard number

5. Policyholder to complete

CLAIM DETAILS

Please tell us which benefit/s you are claiming for (refer to your policy Terms and Conditions to check the sections of cover available on your policy)

Death

Permanent blindness in one or both eyes

Loss of one or both hands or arms

Loss of one or both feet or legs

Permanent total disability

Temporary total disability

Dental treatment

Hospital benefit

Tuition fees

PLEASE SELECT A PAYEE AND COMPLETE POLICYHOLDER NAME AND DATE IN THIS SECTION**WHO WOULD YOU LIKE US TO PAY**

Payment can be made out to the injured person if they are not the policyholder. Please confirm below who claim settlement should be made to:

 Policyholder

If the claimant is the policyholder, claim payments will be paid into the bank account from which your premium is collected. Please ensure you have given us your email address in Section 2 to avoid delay in settlement.

 Other Injured Person

If the claimant is not the policyholder, cheques will be made payable to the injured person.

HAVE YOU ATTACHED ALL NECESSARY DOCUMENTS?

I/we declare that all the above statements are true in every respect and that I/we have fulfilled the Terms and Conditions of the policy.

Policyholder name

Date / /

IMPORTANT NOTES

- Please include all required documentation, including invoices
- Please send completed claim forms including copies of required documentation to: equine-claims@allianz.co.uk or Petplan Equine, PO Box 222, Huddersfield, HD8 1FQ.

**INCOMPLETE CLAIM FORMS WILL BE RETURNED TO THE POLICYHOLDER
PLEASE NOW PASS THIS FORM TO YOUR DOCTOR OR DENTIST**

7. Medical/Dental practitioner to complete at the policyholders expense

MEDICAL / DENTAL CERTIFICATE

Injured person's name and address

Mr/Mrs/Ms/Miss Surname Initial

Address

Postcode

Are you the insured person's usual medical/dental attendant Yes No

If yes, for how long have they been registered with you?

When did you first attend the injured person for the injuries? / /

What do you believe to be the cause of the injury?

What is the nature and extent of the injuries sustained?

(a) Please state the area of the body affected (e.g. left/right/upper/lower/limbs/hands/feet/jaw)

(b) Will the injuries give rise to:

(i) Permanent Loss of limb, eye or hearing? Yes No

(ii) Permanent Total Disability entirely preventing the injured person from any type of work? Yes No

(iii) Temporary Total Disability preventing the injured person from attending to any part of his/her occupation? Yes No

(iv) The hospitalisation of the injured person? Yes No

If you have answered YES to the above questions please give full details:

If you have answered YES to questions (iii) or (iv) above please give the dates from which incapacity/hospitalisation commenced and ended.

From / / To / /

Are there any aspects of the injured person's previous medical/dental history which may have a bearing on this claim?

Please state the total cost of the injured person's treatment or estimate if treatment not yet concluded (deleting any treatment cost unrelated to the accident)

£ -

Has treatment finished? Yes No

Medical/Dental Practitioner

Name

Address

Postcode

Date / /

Professional qualifications

Medical/Dental Practitioner name

Date / /