MasterCare Policy Claim Form

Policyholder Checklist:

- ☐ Detailed invoices for condition(s) being claimed are attached
- ☐ Claim form is **fully** completed by both you and your veterinarian
- ☐ Complete medical history is attached if not previously submitted

Policy #_____

Policy Type_____

Part 1 – To be completed by the policyholder (please print)

Please refer to your Policy Terms and Conditions for the time limitation on submitting claims.

Policyholder: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Telephone: (____)_____ Fax: (____)_____ Email: _____

Please tick if there has been a change of address: ☐

Pet's Name: _____ Species: _____

Sex: ☐ Male ☐ Female Age: ____ Breed: _____

To be completed only in the event of accidental death

If this is a claim for Accidental Death Benefits please attach original purchase receipt.

Nature of Accident: _____

Cause of Death: _____

Date of Accident: ____/____/____ (D / M / Y)

Name and phone number of any witnesses: _____

Signature of Official or Veterinarian: _____

To the best of my knowledge, the following statements are true in every respect and I have abided by all of the Policy Terms and Conditions. I understand that any misrepresentation or omission of any material fact can result in denial of the claim.

Signature of Policyholder: _____ Date: ____/____/_____ (mm/dd/yy)

Part 2 – To be completed by the Veterinary Clinic ONLY

Please list the medical Illness/Accident for which the policyholder is making a claim: _____

_____

_____

Date accident occurred or clinical signs of illness first noted:_____/_____/_____ (mm/dd/yy)

Was this accident fatal? ☐ Yes ☐ No

Has this pet received treatment for this Illness/Accident in the past? ☐ Yes ☐ No

If "Yes" is this condition ongoing from a previous occurrence? ☐ Yes ☐ No

Has this pet had an annual physical examination in the past 12 months, and up to date on all recommended vaccinations? ☐ Yes ☐ No

How long has this pet been a client of your clinic? ☐ Less than 18 months ☐ More than 18 months

I confirm that to the best of my knowledge, the above statements are true in every respect.

Signature of Attending Veterinarian:_____ D.V.M. Date:____/____/_____ (mm/dd/yy)

Name of Veterinarian:_____

Practice Stamp

Please forward completed forms to:
QuickCare Pet Insurance Programs
710 Dorval Drive, Suite 400
Oakville, Ontario L6K 3V7

Toll Free: 1-866-275-PETS
Fax: 1-866-368-PETS (7387)
www.quickcarepetinsurance.com