

Cash Plan claim form

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

If you are a NHS Dental Plan or Private Dental Plan policyholder, complete sections (A),(B),(E) only

If you are a **Health Plan policyholder**, complete sections **(A),(C),(E) only**

If you are claiming for Hospital Cash, complete sections (A),(D),(E) only

A				
Policy No.	Date of Birth			
First Name	Please place a cross in this box if this is a change of address			
Surname	II this is a change of address			
House Number/Name				
·				
Street				
Town	Postcode			
Contact Tel No.				
Email Address				
Panendent Child receiving treatment if different to policyholder.				
Dependent Child receiving treatment if different to policyholder				
Title	Surname			
First Name(s)				
Date of Birth				
B Dental Claim				
Dental Please enclose a receipt from Dentist to support your claim	Date of previous dental examination if this is your first claim			
Dental Accident	Cost of treatment £ .			
Please enclose a receipt which specifically confirms that treatment is a consequence of an accidental injury and provide written details of the accident.				
C Health Plan – All other benefits				
Treatment claimed for Cost of treatment	£			

D Hospital Claim			
Was admitted as an Inpatient.	Day the patient was admitted		
Was admitted as a Day Bationt	Day the patient was discharged		
Was admitted as a Day Patient	Date		
Please state medical procedure and include any supporting documents required to make this claim, e.g discharge papers/appointment letters			
E Declaration and Access to Medical Reports Act 1988			
I declare that the above information is correct. I cancellation of my membership. I hereby authorise the relevant medical practition		_	
Please tick Signature	Date	e	
Checklist!	n? ✓ Is this claim within 6 months o	f the date of treatment?	

RETURN TO: BDHSC, PO BOX BOLTON, PO BOX 335, S98 1BY

Queries completing this form? Please call us on **01204 522 775** or email **info@ukhealthcare.org.uk**