



Pet

## PET CLAIM FORM

Register your claim on the OUTsurance app or by calling us on 08 600 70 000.

Please email your completed claim form to [petclaims@out.co.za](mailto:petclaims@out.co.za) (include your claim number in the subject line).

For more information, please visit [www.outsurance.co.za](http://www.outsurance.co.za).

### Submission check form:

- Completed claim form (Not required for routine care claims)
- Detailed invoice
- Proof of payment
- Full veterinary history if this is your pet's first claim (not required for routine care claims). A vaccination certificate is not sufficient.

### Policy holder details

|                         |  |                         |  |
|-------------------------|--|-------------------------|--|
| Policy / Claim / ID no. |  |                         |  |
| First name              |  | Surname                 |  |
| Contact no.             |  | Alternative contact no. |  |
| Email                   |  |                         |  |

### Pet details

|  |  |        |                               |                                 |
|--|--|--------|-------------------------------|---------------------------------|
| Pet name                               |  | Gender | Male <input type="checkbox"/> | Female <input type="checkbox"/> |
| Breed                                  |  |        |                               |                                 |
| Microchip / tattoo no. (if applicable) |  |        |                               |                                 |

### Claim Details - Client to complete

|  |  |                                   |                              |                             |
|--|--|-----------------------------------|------------------------------|-----------------------------|
| Is this a continuation of a prior claim?     |  |                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, what is the claim number (optional)? |  | Date of previous claim (optional) |                              |                             |

### Claims Details - Vet to complete

|                                  |                                   |                                       |                                    |                                       |  |
|----------------------------------|-----------------------------------|---------------------------------------|------------------------------------|---------------------------------------|--|
| Date first showed clinical signs | YYYY / MM / DD                    | Medical diagnosis or accidental event |                                    |                                       |  |
| Date of treatment                | YYYY / MM / DD                    |                                       |                                    |                                       |  |
| Type of claim                    | <input type="checkbox"/> Accident | <input type="checkbox"/> Illness      | <input type="checkbox"/> Vet visit | <input type="checkbox"/> Routine care |  |

## Claims Details - Vet to complete (continued)

|   |  |               |  |
|---|--|---------------|--|
| Was the pet admitted at the practice?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |               |  |
| Is this a continuation of a condition that existed before the treatment date? | <input type="checkbox"/> Yes <input type="checkbox"/> No |               |  |
| Is this a hereditary condition?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |               |  |
| Is this a congenital condition?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |               |  |
| Is the treatment chronic?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |               |  |
| Additional vet notes:   |  |               |  |
| <br><br><br><br><br><br><br><br><br><br>                                      |  |               |  |
| Amount claimed (as per invoice)   | R  | Practice name |  |

Practice stamp \_\_\_\_\_ Date         YYYY / MM / DD        

## Declaration

I/we certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/we understand that deliberate misrepresentation of the animal's condition or the omission of any material facts will result in the denial of the claim and/or cancellation of the policy. I/we confirm that the veterinary services as detailed in account(s) submitted with this claim have been provided and I/we understand that policy administrators will assess the claim in accordance with the cover selected and benefits payable by the policy. I/we authorise any veterinary surgeon who has treated my/our pet to provide to the insurer any details they may require. Please note that issuance or completion of this form does not acknowledge the liability or guarantee payment of the claim.

Policy holder signature \_\_\_\_\_

Veterinary signature \_\_\_\_\_