PO Box 340, Sheffield S98 1XB
0114 250 2000
8:30am-5:30pm Monday to Friday
enquiries@westfieldhealth.com
westfieldhealth.com

Did you know you can now claim online for all benefit types at **westfieldhealth.com/mywestfield** or via our app.

Please write carefully in black ink within the boxes in block capitals.
Please ensure you complete the claim form in full.
Failure to do so may result in a delay in processing your claim.

Claim Form- Health Cash Plan

Part 1

Westfield Account No.

Date of Birth (Day / Month / Year)

Surname

Please place a cross in this box if this is a change of address

First Name

House Number/Name

Street

Town

Postcode

Mobile no.

Email address

Claim payment confirmation will be sent to you by email, if you haven't done so already please provide an up to date email address.

If you wish your payment to be paid directly into the bank, then please enter your account details. If you have already provided these details then there is no need to fill them in again unless your account details have altered.

Account No.

Sort Code

Please fill in this section if the claim is for your dependent child.

Dependent Child's Surname

Date of Birth

Dependent Child's First Name

Declaration and Signature

Westfield Contributory Health Scheme Ltd. will only pay a proportionate share of any claim if you have other health insurance in place. If you have another insurance policy that may cover this claim, please tick to say whether or not you intend to claim on that insurance policy. If you tick Yes, please provide full details of the other insurance provider and the amount being claimed.

Yes ☐ No ☐

Fraudulent Claims / Fair Processing Notice

In the interest of all of our customers, detection of fraudulent claims may result in legal action being taken, immediate cancellation of your policy and all benefit rights. We may also seek to recover any monies paid to you that were not due under the Terms and Conditions of this policy. For audit purposes we will carry out checks on the information you and practitioners provide to us, this may include information relating to health and medical conditions. For the detection and prevention of fraud we may share this information with other insurance providers; selected third parties; police and other enforcement agencies; and the employer (if they are paying some or all of the premium for your cover) where we have a reasonable belief that the claims activity is in serious breach of our terms and conditions and/or may be fraudulent. Westfield Health take your privacy very seriously, if you would like to know more about how we process your data, please see our detailed Privacy Notice, which is available on our website.

I declare that the information shown on this form and any accompanying documentation is true and complete. I will give you any proof or further information you ask for. I authorise any medical practitioner or other person(s) concerned with providing health care to give you any information relevant to this claim and or my policy. Where I have provided information about another person I have obtained their consent to do so.

Policyholder's Signature X..... Date (Day / Month / Year)

Please refer to your policy schedule or benefit table to determine the benefits that are applicable to your cover.
Please check these carefully to confirm your cover before receiving treatment or paying for goods and services for which you intend to claim.

For the benefits shown below, please enclose the relevant original receipt. For claims for a dependent child, give their details in Part 1. We will check the information you give us. Your receipt should clearly show the name and address of your practitioner.

Part 2 Please place a cross in the box showing the benefit you are claiming. Please enclose the receipt and state how much you paid.

Optical — You ☐ Dependent child ☐ — £ . — Date of receipt (Day / Month / Year)
Please enclose the receipt and say how much you paid

Dental — You ☐ Dependent child ☐ — £ . — (Day / Month / Year)
Please enclose the receipt and say how much you paid

Dental Accident — You ☐ Dependent child ☐ — £ . — Date of receipt (Day / Month / Year)
The receipt should state that treatment is a consequence of an accidental injury and provide written details of the accident.

For all claims in this section your receipt should clearly show the practitioner's/healthcare professional's name and the professional organisation they are registered with/a member of.

	You	Dependent child		You	Dependent child		You	Dependent child		You	Dependent child
Physiotherapy	☐	☐	Acupuncture	☐	☐	Osteopathy	☐	☐	Chiropody	☐	☐
Chiropractic	☐	☐	Consultation*	☐	☐	Homeopathy	☐	☐	Health Screening	☐	☐

Please enclose the receipt and say how much you paid — £ . — Date of receipt (Day / Month / Year)

* You must name the medical professional who recommended the consultation

Please name the condition you are receiving treatment for.

Part 2 - continued

For all claims in this section your receipt should clearly show the practitioner's/healthcare professional's name and the professional organisation they are registered with/a member of.

	You		You		You		You		You
Acupressure		Indian Head Massage		Reiki		Allergy Testing/ Food Intolerance		Nutritional Therapy	
Aromatherapy		Reflexology		Sports Massage		Hypnotherapy			

Please enclose the receipt and say how much you paid £ . Date of receipt Day Month Year

Maternity/Paternity/Adoption — Please send us a copy of your child's full birth certificate - don't send the original certificate.

Please refer to your policy schedule or benefit table to determine the benefits that are applicable to your cover.
Please check these carefully to confirm your cover before receiving treatment or paying for goods and services for which you intend to claim.

For the benefits shown below, please enclose the relevant original receipt. For claims for a dependent child, give their details in Part 1. We will check the information you give us. Your receipt should clearly show the name and address of your practitioner.

Part 3 Please place a cross in the box showing the benefit you are claiming.

For claims in this section please send us a copy of your discharge letter as evidence of your admission.

	You	Dependent child		You	Dependent child
Inpatient			Day Surgery		

Please state medical procedure including any treatment e.g. chondroplasty, as we do not cover tests or investigation e.g. biopsies or endoscopies carried out for investigation purposes only.

Was allocated a bed or a similar facility that the treatment provider classes as a bed (Usually for a period of supervised recovery) Yes No

Underwent a Surgical Procedure** using theatre facilities Yes No

**A procedure requiring the use of local, regional or general anaesthetic, for the purpose of treating disease, injury or abnormality by operating directly on or removing the affected part, or removing a foreign body.

For benefits shown below please enclose the relevant original receipt clearly showing your name and the name and address of the dispensing practitioner. We will not accept debit/credit card receipts or photocopies.

Prescription Charges — Please say how much you paid £ . Date of receipt Day Month Year

If you have purchased a Prescription Pre-payment Certificate (PPC) you must provide us with evidence of this eg: a copy of the PPC11 letter issued by the NHS Business Services Authority when they issue your PPC.

Is the PPC valid for 3 months 12 months Date of receipt Day Month Year

Flu Jab & Vaccinations

Please say how much you paid £ . Date of receipt Day Month Year

Name of vaccination .....

We will only pay benefit under the General Terms and conditions and Benefit Rules shown in our current plan guide.
We must receive claims within 26 weeks of the date of each receipt or the date of treatment for which you are claiming benefit.
If any documentation submitted is found to be untrue, this may lead to the termination of your policy.