



Pet Insurance Claim Form For Boarding Fees and Daily Minding

Please send this form to Atlas Insurance PCC Limited – Ta' Xbiex Seafront, Ta' Xbiex, Malta. Do not forget to attach original accounts (invoices or receipts) where applicable. PLEASE FILL IN ALL DETAILS and use BLOCK capitals throughout.

Policy No.

Making a claim

Please follow these instructions carefully to ensure that your claim will be processed efficiently and without any need for further clarification.

1. Your doctor must complete section 5 of this claim form.
2. Claims should be submitted as soon as possible and not later than 2 months from the date expenses were incurred and must include
 - a. the invoices and/or receipts from the boarding establishment or written confirmation from the person looking after your pet indicating the relevant dates.
 - b. the discharge certificate from the hospital that confirms the dates of your admission and subsequent discharge from the hospital.
3. We recommend that you photocopy the completed form and any enclosures for your records.
4. We are unable to accept original receipts where alterations have been made unless such alteration is signed by the person issuing the receipt.

1. About You - to be completed by Policyholder(s)

Policyholders' Full Name ID. Card No.
Postal Address
Telephone No. Mobile No.
Email Address

2. About Your Pet - to be completed by Policyholder(s)

Your Pet's Name Microchip Number
Male Female Dog Cat
Breed

3. Boarding Kennel/Home Carer

Name of Boarding Kennel / Home Carer
Address of Boarding Kennel / Home Carer
Telephone No. Boarding fees per day: €
Date of boarding/Homecare: from to

5. Insured's Direct Credit Details

Please complete your bank details if you wish us to transfer claim settlement into your bank account.

Bank Account details	<input type="text"/>
Name of Bank	<input type="text"/>
Country	<input type="text"/>
IBAN No.	<input type="text"/>

6. About the Illness or Injury - to be completed by Policyholder(s) General Practitioner or Hospital Physician/Surgeon

Policyholders' Name	<input type="text"/>
Name of G.P./ Physician/Surgeon	<input type="text"/>
Name of Admitting Hospital	<input type="text"/>

Date of Hospitalisation: from to

Medical Condition requiring hospital treatment

Date of first visit to any doctor for this condition

Name of the illness or injury, or state the clinical signs if you have not yet made a diagnosis

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

Signature of G.P./Hospital Physician/Surgeon (please delete as applicable) _____

Telephone No. _____ Date

Stamp _____