UK Healthcare™
Looking after every body

Health Cash Plan claim form

Person receiving treatment (policyholder or partner)

Title Surname

First name(s)

Policy number Contact number

Date of birth D D M M Y Y Y Y

Address

Postcode

Email

Claim

Treatment claimed for

Amount of receipt £ .

Dependent child receiving treatment

Title Surname

First name(s)

Date of birth D D M M Y Y Y Y

Payments

Account name

Sort code Account number

Declaration and Access to Medical Reports Act 1988

I declare that the above information is correct. I understand that fraudulent claims will result in legal action and cancellation of my membership. I hereby authorise the relevant medical practitioner to divulge any information relating to the above claim.

Please tick Signature Date D D M M Y Y Y Y

Checklist:

- ✔ Have you ticked the declaration?
- ✔ Is this claim within 6 months of the date of treatment?
- ✔ Are appropriate receipts (plus debit/credit card receipts) attached?

RETURN TO: UK Healthcare, PO Box Bolton, PO Box 335, S98 1BY