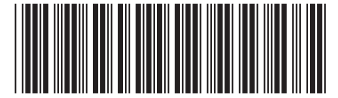
UK Healthcare™

Health Cash Plan claim form

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



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 3 months of the date of treatment?

✓ Are appropriate receipts (plus debit/credit card receipts) attached?

RETURN TO: UK Healthcare, Ground Floor, Regent House, Folds Point, Folds Road, Bolton, Lancashire BL1 2RZ