

engage Health Cash Plan claim form



Please complete this form in full to claim your benefits. For personal accident claims please request the relevant claim form by calling 0800 988 2129*.

Part A – claimant's details

Please complete your details using block capitals

Membership No. Title Mr Mrs Ms Miss

Surname

Forename(s)

Address

Postcode

Date of birth dd / mm / yyyy Telephone number

If premiums are paid through payroll deductions please complete the following information

Name of employer where contributions paid Payroll No.

Part B – child's details

Please complete only if you are claiming benefit on behalf of a child

Child's surname

Child's forename Child's date of birth dd / mm / yyyy

Part C – details of claim

Please tick the relevant box(es) to show which benefit(s) you are claiming and fill in the amount and the date of a receipt.

Plan type	Amount	Date of receipt	Plan type	Amount	Date of receipt	Plan type	Amount	Date of receipt
Optical (you) <input type="checkbox"/>	<input type="text"/>	<input type="text"/> dd mm yyyy	Physiotherapy <input type="checkbox"/>	<input type="text"/>	<input type="text"/> dd mm yyyy	Acupuncture <input type="checkbox"/>	<input type="text"/>	<input type="text"/> dd mm yyyy
Optical (child) <input type="checkbox"/>	<input type="text"/>	<input type="text"/> dd mm yyyy	Osteopathy <input type="checkbox"/>	<input type="text"/>	<input type="text"/> dd mm yyyy	Health Screening <input type="checkbox"/>	<input type="text"/>	<input type="text"/> dd mm yyyy
Dental (you) <input type="checkbox"/>	<input type="text"/>	<input type="text"/> dd mm yyyy	Chiropractic <input type="checkbox"/>	<input type="text"/>	<input type="text"/> dd mm yyyy	Maternity/ Paternity/Adoption <input type="checkbox"/>	<input type="text"/>	<input type="text"/> dd mm yyyy
Dental (child) <input type="checkbox"/>	<input type="text"/>	<input type="text"/> dd mm yyyy						

Please provide more details if you are claiming any benefit apart from optical or dental

Part D – hospital in-patient and day surgery benefit

Please complete only if you are claiming hospital in-patient or day surgery benefit

Name of person who received treatment

Was a patient in (name of hospital) Ward No.

Details of admission (please tick as appropriate) General Maternity Accident Day Surgery

Please provide full details

Stayed in hospital from dd / mm / yyyy to dd / mm / yyyy

Please give details of any hospital leave during the above dates:

from dd / mm / yyyy to dd / mm / yyyy from dd / mm / yyyy to dd / mm / yyyy

To be completed by the hospital

We hereby certify that the above information is correct

Specialty

Unit No. Position

Signed Date dd / mm / yyyy

Hospital stamp

Declaration

I wish to make a claim for the benefit(s) stated and confirm I am eligible to claim. I understand that any receipts which have been altered will be rejected and fraudulent claims will result in immediate withdrawal of membership. Any medical practitioner or other person concerned with providing healthcare may give you any information relevant to this claim that you ask for.

Signed Date dd / mm / yyyy

Office use only. Type of Plan:

Office use only. Claim No.

How to claim benefits

Please read in conjunction with the Policy Summary. Benefits are applicable anywhere within the European Community.

ALL CLAIMS MUST BE SUBMITTED WITHIN 3 MONTHS OF RECEIPT DATE, UNLESS STATED OTHERWISE. All benefits will be paid by cheque and sent directly to the claimant's home address. Receipts will be retained for audit purposes.

We cannot accept liability for any charges incurred in the completion of claim forms or provision of medical certificates.

Optical

Please send in the completed claim form with the **original** receipt showing the amount paid and the claimant's name. For optical continuing supply scheme payments please see Benefit Rules in the Policy Summary.

Dental

Please send in the completed claim form with the **original** receipt showing the amount paid and the claimant's name. The receipt must also show the name and address of the Dentist/Dental Practice.

Hospital in-patient and Day Surgery

Please complete Part D overleaf to claim under this benefit. A separate claim form must be completed for each hospital in which you or the child were patients.

Maternity, Paternity and Adoption

Please send the completed claim form with your child's **original** birth certificate or adoption papers, which will be returned. If child's surname differs from claimant's surname, please supply child's birth certificate showing names of both parents. Benefit is payable only when the birth or adoption has taken place.

This benefit covers the first 9 nights of any hospitalisation related to pregnancy. The hospital certificate must be obtained for any period in excess of 9 nights.

Health Screening

Please submit the claim form with the **original** receipt from the health screening clinic showing the type of screening received and amount charged.

Physiotherapy, Osteopathy, Chiropractic and Acupuncture

Please send in the completed claim form with the **original** receipt showing the amount charged. Each visit and amount paid must be shown separately.

Personal Accident Cover

Please contact Customer Services on 0800 988 2129* for a personal accident claim form.

Once you have completed the claim form, please return it with the required supporting information to:

engage Mutual Insurance Limited,

Claims Department,

Hornbeam Park Avenue,

Harrogate,

HG2 8XE

* Calls may be recorded for security and training purposes. Lines open Mon-Fri 9am-5pm.



engage Mutual Assurance is a trading name of engage Mutual Services Limited ("eMSL"), registered number 3088162 of Hornbeam Park Avenue, Harrogate HG2 8XE and engage Mutual Insurance Limited ("eMIL"), registered in Gibraltar number 100605 of Montagu Pavilion, 8-10 Queensway, Gibraltar. Premier Health Benefits is a trading style of engage Mutual Insurance Limited. eMSL is an appointed representative of eMIL.

eMIL is authorised to conduct general insurance business by the Financial Services Commission Gibraltar (FSCG) and is regulated by the Financial Services Authority for the conduct of UK business. eMIL's FSA Register number is 485680. You can check this on the FSA's Register by visiting the FSA's website www.fsa.gov.uk/register or by contacting the FSA on 0845 606 1234.