

### Policyholder Details

Policy Number

Policyholder Name

### Pet Details

Pet Name

Pet microchip number

### Claim Details

Date you first noticed signs of your pet's condition(s):

Description

Claim Amount: \$ , .

### Veterinary History

Please provide details of previous veterinary practices visited by this pet.

Vet Practice Name (1):

Address (Suburb/ State):

Vet Practice Name (2):

Address (Suburb/ State):

### Payment Details

Payment will be made into the bank account you have registered with us. If these details have changed, please call us before submitting this claim.

### Policyholder Declaration

Please provide a clear, itemised invoice with this claim. Where a client discount has been applied to the fees, please ensure this has been indicated on the invoice.

I certify, to the best of my knowledge, that all the information provided by me is true, accurate and complete. I understand that in the event this claim is found to be fraudulent, this could result in my policy being cancelled.

I agree that my veterinarian and any previous veterinary practices may provide any information that the company requires to verify my claim (including medical notes).

I understand that any incorrect or missing information may result in a delay or declination of this claim.

Signature of policyholder

Date

### Next Steps

The next section is to be completed by the treating veterinarian(s) and/ or specialist. Please bring this form to your Veterinarian to complete. Then, return to us by email or post.

Email: [claims@pet.budgetdirect.com.au](mailto:claims@pet.budgetdirect.com.au)

Address: Auto & General Insurance Company, PO Box 342, Toowong, QLD, 4066

Please complete sections A, B & E. If the pet was treated for more than one condition, please complete section C. If additional conditions are being claimed for, please photocopy and complete an additional Section C. Complete section D, if applicable.

**A. Consultation Details**

When was the pet first registered at the practice?  /

If the pet was referred, please provide details of the referring veterinary practice.

Name of Veterinarian: \_\_\_\_\_ Practice Name: \_\_\_\_\_

If a house visit was performed, please provide the Travel Fee charged (or portion of consult fee):

\$ \_\_\_\_\_ .

If an Out-of-Hours consult/ treatment was performed, please provide the Out-of-hours fee charged (or portion of consult fee):

\$ \_\_\_\_\_ .

If this pet has been on any regular medication, treatment or prescription diet to control or treat a condition for the last 12 months, please provide details: \*

**B. Condition 1**

Diagnosis and location: e.g. Otitis Externa – left ear (list major complaint or differential diagnosis list if no diagnosis made)

Diagnosis: \_\_\_\_\_

OR

Major Complaint: \_\_\_\_\_

Circle area of the body/ body system affected:

Ear Eye Gastrointestinal Hepatic Renal/ urinary Reproductive Respiratory Dermatological Neurological

Musculoskeletal Cardiovascular Endocrine (hormonal) Immune mediated/ Autoimmune Poisoning/ Toxicity

Tumour/ Mass/ Neoplasia (benign/ malignant)

Other: \_\_\_\_\_

What treatment/ test/ procedure/ surgery was performed?

Please tell us the treatment dates for this claim: From  /  To  /

Date when signs, symptoms, abnormal behaviour were first noticed by owner?  /

If the pet has been seen for this illness or injury before, please provide date of first signs or symptoms: \*  /

\*Medical notes may be requested

If the pet has been seen for any similar or related illness or injury or clinical signs before (includes elsewhere in or around the body):

Please provide date:  /  Please explain: \_\_\_\_\_

**C. Condition 2** (complete if more than one condition)

**Diagnosis and location:** e.g. *Otitis Externa – left ear* (list major complaint or differential diagnosis list if no diagnosis made)

Diagnosis:  OR Major Complaint:
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**Circle area of the body/ body system affected:**

Ear   Eye   Gastrointestinal   Hepatic   Renal/ urinary   Reproductive   Respiratory   Dermatological   Neurological Musculoskeletal   Cardiovascular   Endocrine (hormonal)   Immune mediated/ Autoimmune   Poisoning/ Toxicity Tumour/ Mass/ Neoplasia (benign/ malignant) Other:
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**What treatment/ test/ procedure/ surgery was performed?**

Please tell us the treatment dates for this claim:    From     To

Date when signs, symptoms, abnormal behaviour were first noticed by owner?

If the pet has been seen for this illness or injury before, please provide date of first signs or symptoms: \*

\*Medical notes may be requested

If the pet has been seen for any similar or related illness or injury or clinical signs before (includes elsewhere in or around the body):

Please provide date:     Please explain:

**D. Complete if applicable only:**

<p>If this claim is for cruciate ligament problems: *</p> <p>Please provide date first noted/ first signs/ symptoms:</p> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0; display: flex; align-items: center; justify-content: center;"> <span style="margin-right: 10px;">/</span> <span style="margin-right: 10px;">/</span> </div>	<p>Please provide details if there were any underlying disease or conformation issues (e.g. Patella luxation) previously noted:</p>
<p>If this claim is for a condition that pets are routinely vaccinated against:</p> <p>Please provide date of last vaccination:</p> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0; display: flex; align-items: center; justify-content: center;"> <span style="margin-right: 10px;">/</span> <span style="margin-right: 10px;">/</span> </div>	<p>Type of vaccination:</p>
<p>If death or euthanasia resulted from this illness or injury:</p> <p>Please provide date of death:</p> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0; display: flex; align-items: center; justify-content: center;"> <span style="margin-right: 10px;">/</span> <span style="margin-right: 10px;">/</span> </div>	<p>If euthanised, did you recommend this?</p>
<p>If this claim is for fractured/ damaged/ broken teeth or a tooth:</p> <p>Was the tooth or teeth damaged/ fractured or broken due to an injury?</p> <p>Yes                  No</p>	<p>If there was any existing disease relating to these teeth or tooth, please explain: *</p>
<p>If this claim is for Intervertebral Disc Disorder (IVDD): *</p> <p>If the pet had any sign, symptoms or treatment for any problem <u>in this area</u> previously, please provide the date of first signs/ symptoms:</p> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0; display: flex; align-items: center; justify-content: center;"> <span style="margin-right: 10px;">/</span> <span style="margin-right: 10px;">/</span> </div>	<p>Details:</p>
<p>If this claim is for a hip condition: *</p> <p>If there are any underlying disease or conformation issues (i.e. dysplasia, subluxation) previously noted, please provide date first noted/ first signs/ symptoms:</p> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0; display: flex; align-items: center; justify-content: center;"> <span style="margin-right: 10px;">/</span> <span style="margin-right: 10px;">/</span> </div>	<p>Details:</p>
<p>If this claim is for Paralysis Tick toxicity:</p> <p>Provide date of last preventative treatment:</p> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0; display: flex; align-items: center; justify-content: center;"> <span style="margin-right: 10px;">/</span> <span style="margin-right: 10px;">/</span> </div>	<p>Preventative Product used:</p>
<p>If this claim is for a lump/ mass/ tumour:*</p> <p>If this pet has had a lump of the <u>same</u> diagnosis previously, please provide date of first signs:</p> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0; display: flex; align-items: center; justify-content: center;"> <span style="margin-right: 10px;">/</span> <span style="margin-right: 10px;">/</span> </div> <p>If this pet has previously had lumps that have <u>not been diagnosed</u> by histology or cytology, please provide date of first signs:</p> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0; display: flex; align-items: center; justify-content: center;"> <span style="margin-right: 10px;">/</span> <span style="margin-right: 10px;">/</span> </div>	<p>Histological/ cytological diagnosis (if performed):</p>

\* Medical notes may be requested.

Please provide a clear, itemised invoice with this claim. If there are multiple conditions claimed, please label "1", "2" corresponding to each condition against EACH invoice item.

### E. Veterinarian Declaration

I certify, to the best of my knowledge, that all the information provided by me is accurate and complete.

I also confirm that the fees charged are my normal practice fees relating to this matter and are no more than the fees I would normally charge my clients. Where a client discount has been applied to the fees this has been clearly indicated on the invoice.

I understand that any incorrect or missing information may result in a delay or declinature of this claim. I also understand that Budget Direct Pet Insurance may ask the practice to provide a full medical history record to assess this claim.

**Veterinarian Signature**

**Date**

**Print Name**

**Registration No.**

**Name and address of veterinary practice**

**Suburb**

**State**

Thank you for completing this form. If we require further documentation or medical notes our Claims team might be in contact with you. Please provide the best contact details for our claims team to contact you:

**Veterinarian Email**

**Veterinarian Telephone Number**

To speak directly to one of our Veterinary officers, please call **1800 931 667 (Vet Hotline)**, Monday to Friday 8am - 5pm (AEST)

### F. Checklist

Complete and sign the claim form

Ensure your vet has completed and signed the 'Veterinarian declaration' section of the claim form.

Attach your vet's itemised invoice/s

Send your completed claim form and invoice/s to us:

**Email**

[claims@pet.budgetdirect.com.au](mailto:claims@pet.budgetdirect.com.au)

**Mail**

Auto & General Insurance Company, PO Box 342, Toowong QLD 4066