



FOR OFFICE USE ONLY

Please refer to your membership plan when claiming benefits. Please make sure you complete your member number as your claim could be delayed.

1. Member's Personal Details

Member number

You can use your member number or email address to check your benefit allowances and submit receipt-based claims online by visiting the Members' Area on our website www.healthshield.co.uk

Address

Title

Postcode

Surname

Telephone number

Forename(s)

Personal Email

Date of birth (DD/MM/YY)

I want to be paperless, please send all my Health Shield membership information by email

2. Your Claims

Please ensure that you enclose all the relevant, original receipts with this claim form. If you have had a series of treatments the receipt must show the date and cost for each treatment. Please also refer to the 'How to Claim' section on our website for full receipt details. If claiming for a private medical insurance (PMI) excess fee please also refer to Section 4.

I am claiming for

Forename	You	Partner	Child	Date of birth (DD/MM/YY)	Benefit	Amount paid	Treatment date (DD/MM/YY)	Medical reason for treatment
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
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3. Benefit Payment Direct to your Bank Account

Please enter your bank details below. If you have already provided these details then there is no need to fill them in again unless your account details have altered, or we hold more than one account on your policy. We no longer pay benefit by cheque. If this is a problem then please contact us on 01270 588555.

Bank/Building Society name Account number Sort code

4. Private Medical Insurance (PMI) Excess Fees

Before making a claim please refer to your membership plan to ensure that excess fees are covered under your policy.

If this is to be paid directly to your practitioner please enter their details below (if these details are not clear or not completed fully the payment will be made to you):

Make cheque payable to:

Practitioner Address:

Please enclose a copy of your PMI statement from your PMI insurer to support this claim and please make sure you have also completed Section 2 above.

5. Member's Authorisation and Signature

Please print this form and sign in the box below before returning to Health Shield

- I declare that all the information included is accurate, true and complete to the best of my knowledge and belief.
- I agree that Health Shield can confirm the details with the healthcare provider.
- I understand that Health Shield may end my membership if my claim is found to be fraudulent.

Your signature

Date

 (DD/MM/YY)

Fraudulent claims – Health Shield are committed to preventing financial crime and we will report to the police all instances of fraud or attempted fraud.

Please return to

Please return this form, along with all necessary additional information and receipts to Health Shield. We aim to turnaround all receipt based claims within two working days.

Health Shield Friendly Society Ltd
Electra Way, Crewe Business Park,
Crewe, Cheshire CW1 6HS

Claims checklist

- ✓ Have you signed and dated section 5?
- ✓ Have you included your membership number?
- ✓ Have you completed sections 2 and 3?
- ✓ Have you attached the relevant receipts, certificates or papers?
- ✓ Is your treatment date less than 12 months ago?
- ✓ Have you read the terms & conditions relevant to the benefit you are claiming?



Health Shield Friendly Society Ltd. Electra Way, Crewe Business Park, Crewe, Cheshire, CW1 6HS
Telephone: 01270 588555 Fax: 01270 251366 Opening hours: 8.00am to 6.00pm, Monday to Friday
Email: info@healthshield.co.uk Website: www.healthshield.co.uk Established in 1877.
Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.
As part of our on-going quality control programme, calls may be monitored or recorded.

PLEASE REFER TO YOUR MEMBERSHIP PLAN WHEN CLAIMING BENEFITS.
PLEASE MAKE SURE YOU COMPLETE YOUR MEMBER NUMBER AS YOUR CLAIM COULD BE DELAYED.
TICK AND/OR COMPLETE THE APPROPRIATE BOXES WHERE APPLICABLE PLEASE PRINT THIS FORM AT 100%
SCALE ON YOUR PRINTER SETTINGS SO IT PRINTS OVER 2 PAGES