

Westfield Health

Westfield House 87 Division Street Sheffield S1 1HT
Customer Helpline: 0114 250 2000
Available from 8am - 6pm Monday to Friday
 Textphone: 0114 250 2020 Fax: 0114 272 4950
 E-mail: enquiries@westfieldhealth.com
 website: westfieldhealth.com



Verify <input type="checkbox"/> Optical <input type="checkbox"/> Dental <input type="checkbox"/>	for office use only
Notes	
	D/C <input type="checkbox"/>
	CHQ <input type="checkbox"/>

Claim form - Foresight

Part 1.

Westfield Account No.

Surname

First Name

House Number/Name

Street

Town

Contact Tel No. Postcode

Email Address

Please circle Date of Birth DAY MONTH YEAR
 Mr/Mrs/ Miss/Ms/ Dr/ Other Please place a cross in this box if this is a change of address

If you wish your payment to be paid directly into the bank, then please enter your account details. If you have already provided these details then there is no need to fill them in again unless your account details have altered.

Account No. Sort Code

Please fill in this section if the claim is for your dependent child.
Please note: This is only available if your Plan covers children's benefits.

Child's Surname

Child's First Name

Date of Birth DAY MONTH YEAR

Is the child resident with the policyholder? Yes No

Declaration

The information shown on this form and any accompanying documentation is true and complete. I will give you any proof you have asked for. Any medical practitioner or other person concerned with providing health care may give you any information relevant to this claim that you ask for.

Policyholder's Signature Date DAY MONTH YEAR

Part 2. Please place a cross in the box showing the benefit you are claiming.

For the benefits shown below, please enclose the relevant original receipted account. Where the treatment is for a dependent child give their details in part 1. (We will check the information you give us). Your receipt should clearly show the name and address of your practitioner.

Optical benefit	(YOU) <input type="checkbox"/>	(DEPENDENT CHILD) <input type="checkbox"/>	£ <input type="text"/>	Date of receipt DAY MONTH YEAR <input type="text"/>
Please enclose the receipt and say how much you paid				
Dental benefit	(YOU) <input type="checkbox"/>	(DEPENDENT CHILD) <input type="checkbox"/>	£ <input type="text"/>	Date of receipt DAY MONTH YEAR <input type="text"/>
Please enclose the receipt and say how much you paid				
Dental Trauma	(YOU) <input type="checkbox"/>	(DEPENDENT CHILD) <input type="checkbox"/>	£ <input type="text"/>	Date of receipt DAY MONTH YEAR <input type="text"/>
Please enclose the receipt and say how much you paid				

For all claims in this section your receipt should clearly show the practitioner's name and qualifications.

Physiotherapy	(YOU) <input type="checkbox"/>	(DEPENDENT CHILD) <input type="checkbox"/>	Date of receipt DAY MONTH YEAR <input type="text"/>
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	Please enclose the receipt and say how much you paid
Osteopathy	<input type="checkbox"/>	<input type="checkbox"/>	£ <input type="text"/>
Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>	
Chiropody	<input type="checkbox"/>	<input type="checkbox"/>	
Consultation*	<input type="checkbox"/>	<input type="checkbox"/>	*You <u>must</u> name the Doctor who recommended the consultation
Homeopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

We will only pay benefit under the General Terms and Conditions and Benefit Rules shown in our current leaflet.
 We must receive claims within 13 weeks of the date of each receipt.
 If any documentation submitted is found to be untrue, this may lead to the termination of your policy.

DID YOU KNOW?

You may be able to **UPGRADE**
your cover or apply for
PARTNER cover too....

See General Terms and Conditions in your
plan leaflet for further details.

Or call the Customer Helpline on:

0114 250 2000

Available from 8am - 6pm

Monday to Friday

(except Christmas Eve & Public Holidays)