

# 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 D/C C/O
Notes	

## Claim form - Health Cash Plans with Children's Benefits

### Part 1.

Westfield Account No.

Surname

First Name

House Number/Name

Street

Town  Postcode

Contact Tel No.

Email Address.

Date of Birth DAY  MONTH  YEAR

Please place a cross in this box if this is a change of address

Please place a cross in this box to receive payment advice via email for all future claims

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 your policy includes child cover and the claim is for your dependent child.

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 in this form 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. Details of the employer through whom your premiums are paid

Name of company .....

Department ..... Payroll number .....

### Part 3. 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 <input type="text"/>	MONTH <input type="text"/>	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 <input type="text"/>	MONTH <input type="text"/>	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 practitioners name and qualifications.**

Physiotherapy	(YOU) <input type="checkbox"/>	(DEPENDENT CHILD) <input type="checkbox"/>	Date of receipt	DAY <input type="text"/>	MONTH <input type="text"/>	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"/>	*You <u>must</u> name the Doctor who recommended the consultation			
Consultation*	<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.