Westfield Health

Westfield House 87 Division Street Sheffield S1 1HT
Customer Helpline: 0114 250 2385
Available from 8am - 6pm Monday to Friday
Textphone: 0114 250 2020 Fax: 0114 272 4950
E-mail: enquiries@westfieldhealth.com
website: westfieldhealth.com

westfield health

Verify ☐ Optical Dental	for office use only
Notes	D/C
	CHQ

Claim form - IoD Health Plan with Children's Benefits

Part 1.

Please circle Mr/Mrs/ Miss/Ms/ Dr/ Other _____

Date of Birth DAY MONTH YEAR

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

Westfield Account No.

Surname

First Name

House Number/Name

Street

Town

Contact Tel No.

Postcode

Mobile No.

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.

Date of Birth DAY MONTH YEAR

Child's Surname

Child's First Name

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 for the employee 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) ☐ (DEPENDENT CHILD) ☐ £ . Date of receipt DAY MONTH YEAR

Please enclose the receipt and say how much you paid

Dental benefit (YOU) ☐ (DEPENDENT CHILD) ☐ £ . Date of receipt DAY MONTH YEAR

Please enclose the receipt and say how much you paid

Health screening (YOU) ☐ £ . Date of receipt DAY MONTH YEAR

Please enclose the receipt and say how much you paid

Consultation (YOU) ☐ (DEPENDENT CHILD) ☐ £ . Date of receipt DAY MONTH YEAR

Please enclose the receipt and say how much you paid
Your receipt should clearly show the practitioner's name and qualifications

You must name the doctor who recommended the treatment .....

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 for which you are claiming benefit.
If any documentation submitted is found to be untrue, this may lead to the termination of your policy.