

# 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



Verify <input type="checkbox"/>	Optical	Dental	for office use only
Notes			
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## Claim form - IoD Health Plan

**Part 1.**

Westfield Account No.

Surname

First Name

House Number/Name

Street

Town

Contact Tel No.

Email 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 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

Please place a cross in this box to receive payment advice via email

**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. If your premiums are taken from your wages or salary or pension please give us the following information**

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. Your receipt should clearly show the name and address of your practitioner.*

Optical benefit  £  .  Date of receipt DAY MONTH YEAR

Please enclose the receipt and say how much you paid

Dental benefit  £  .  Date of receipt DAY MONTH YEAR

Please enclose the receipt and say how much you paid

Health Screening  £  .  Date of receipt DAY MONTH YEAR

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 must name the Doctor who recommended the treatment*

Acupuncture

Osteopathy

Chiropractic

Consultation  Please enclose the receipt and state how much you paid

Homeopathy  £  .  Date of receipt DAY MONTH YEAR

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.