Westfield Health
Westfield House, 60 Charter Row, Sheffield S1 3FZ.
Customer Helpline: 0114 250 2000
Available from 8am-6pm Monday to Friday
E-mail: enquiries@westfieldhealth.com
Website: westfieldhealth.com

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

Claim form - EEF

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

Postcode

Contact Tel No.

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

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 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.

Date of Birth DAY MONTH YEAR

Child's Surname

Child's First Name

Is the child resident with the policyholder? Yes ☐ No ☐

Declaration and Signature

Westfield Contributory Health Scheme Ltd. will only pay a proportionate share of any claim if you have other health insurance in place. If you have another insurance policy that may cover this claim, please tick to say whether or not you intend to claim on that insurance policy. If you tick Yes, please provide full details of the other insurance provider and the amount being claimed. Yes ☐ No ☐

Fraudulent Claims / Fair Processing Notice

In the interest of all of our customers, detection of fraudulent claims may result in legal action being taken, immediate cancellation of your policy and all benefit rights. We may also seek to recover any monies paid to you that were not due under the Terms and Conditions of this policy. For audit purposes we will carry out checks on the information you and practitioners provide to us, this may include information relating to health and medical conditions. For the detection and prevention of fraud we may share this information with other insurance providers; selected third parties; police and other enforcement agencies; and the employer (if they are paying some or all of the premium for your cover) where we have a reasonable belief that the claims activity is in serious breach of our Terms and Conditions and / or may be fraudulent. Westfield Health take your privacy very seriously, if you would like to know more about how we process your data, please see our detailed Privacy Notice, which is available on our website.

I declare that the information shown on this form and any accompanying documentation is true and complete. I will give you any proof or further information you ask for. I authorise any medical practitioner or other person(s) concerned with providing health care to give you any information relevant to this claim and or my policy. Where I have provided information about another person I have obtained their consent to do so.

Policyholder's Signature X.....

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) ☐ (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

Dental Accident (YOU) ☐ (DEPENDENT CHILD) ☐ £ . 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.

	(YOU)	(DEPENDENT CHILD)		(YOU)	(DEPENDENT CHILD)		(YOU)	(DEPENDENT CHILD)
Physiotherapy	☐	☐	Acupuncture	☐	☐	Osteopathy	☐	☐
Chiropractic	☐	☐	Consultation*	☐	☐	Homeopathy	☐	☐

*You must name the doctor who recommended the treatment.

Please enclose the receipt and say how much you paid £ .

Date of receipt DAY MONTH YEAR

We will only pay benefit under the General Terms and Conditions and Benefit Rules shown in our plan guide.
We must receive claims within 13 weeks of the date of each receipt for which you are claiming benefit. If any document submitted is found to be deliberately 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)