Pet Claim Form - Veterinary Fees

Agria Petinsure

This form must be completed by the Policy Holder and the Veterinary Surgeon
Return to: claims@agriapetinsure.ie or Post PO Box 911, Little Island, Cork T45 YR96

Policy Number

☐ Claims for Vet Fees (Please tick)

☐ Pre-Authorisation Request (Please tick)

Policy Holder to complete

Policy Holder Name: _____
Address: _____
_____
_____
_____
_____
Telephone Number: _____
Email: _____

Pet's Name:
Pet Age: Gender: Male Female
Breed:
Date pet came into your possession: DD/MM/YY

**** To be completed for the first claim only***

Please list all Veterinary Practices that have treated your Pet since being in your possession. This includes routine care such as vaccinations.

_____
_____
_____
_____

If this is your first claim, please provide a copy of the Breeder's vaccination card or adoption certificate (if applicable).

For your first claim, you must disclose all Veterinary practices your Pet has attended (for any reason) since being in your possession. Claims will not be reviewed without this information.

Veterinary Practice to complete

Clinical Signs or Diagnosis of Condition being claimed for	Treatment Dates	Cost in €

What is the first visit date for this pet at your practice? DD/MM/YY
Please provide the first date when the Condition being claimed for first commenced. DD/MM/YY

Payee of Claim to Complete

Payment of Claim to be made to (Please Circle): VET Policy Holder

All claim payments will be made by electronic funds transfer (EFT). If we already hold your bank details from previous premium payments or claim settlements, any claim payment will be sent to that account automatically. If your bank details have changed or you need to provide new details, please contact our Customer Services team on 021 202 9119.

Veterinary Declaration
I confirm that the information provided above is correct and that all information held on file for this pet has been provided

Customer Declaration
I confirm that the information I have provided above is true and correct.

Veterinary Signature: _____
Date: _____

Customer Signature: _____
Date: _____

Practice Stamp