# CLAIM FORM

## ADVERTISEMENTS AND REWARDS – Griffe Santé Pet Insurance

**PET OWNER (YOU MAY APPLY A LABEL)**

Family Name: _____ Policy No.: _____
First Name: _____
Address: _____
_____
City: _____
Postal Code: _____
Telephone (home): (____)_____-_____ E-mail (home): _____@_____
Telephone (work): (____)_____-_____ E-mail (work): _____@_____
Cell: (____)_____-_____

**PET**

Name of your pet:_____ Cat ❒ Dog ❒
Race: _____ Male ❒ Female ❒
Colour:_____ Date of birth: _____/_____/_____
Tattoo ID number: _____

**INFORMATION REGARDING THE CIRCUMSTANCES AND THE CLAIM**
**YOU MUST INFORM THE LOCAL AUTHORITIES OF THE LOSS OF YOUR PET (SPCA – SHELTER – POUND - ETC.)**

At what time and on which date did you notice that your animal was missing? Please summarize the circumstances:

_____

_____

_____

Have you informed the local authorities (SPCA – Shelter – Pound - etc.)? Yes ❒ No ❒
If Yes, please indicate the name, address and phone number: _____

_____

If No, please indicate the reason: _____

_____

Are you requesting a reimbursement of expenses incurred for advertisements? Yes ❒ No ❒
*(If Yes, please attach original invoices)*

Has your pet been found? Yes ❒ No ❒
If Yes and you are requesting reimbursement of a reward, please complete the following information:

Name of the recipient of the reward: _____

Telephone: _____

_____
Signature of the recipient of the reward

Is this person a member of your family or a person living with you or employed by you?
Yes ❒ No ❒ If Yes, please explain:_____

Reward amount: $ _____

**DECLARATION OF THE POLICY OWNER**
I understand and accept that the requested fees may not be covered or may exceed the coverage of my insurance policy. I declare that this claim is made in good faith. All fraudulent claims will result in cancellation of the claim and of the policy.

**Please attach original invoices**

_____ _____
Signature of the policy owner Date

# HOW TO MAKE A CLAIM

STEP 1 – Be sure to use the appropriate claim form for the type of claim that you are requesting. You may complete the document on-line and then print it, or you may print it and complete it by hand. IF THIS IS THE CASE, PLEASE WRITE CLEARLY.

STEP 2 – Complete and sign the form where applicable.

STEP 3 – Attach original invoices to this completed and signed form. KEEP COPIES FOR YOUR FILES.

STEP 4 – Mail the form and invoices to the following address:

OPTIMUM®
Optimum Société d'Assurance inc.

**Griffe Santé Claims Department**
**Optimum Insurance Company Inc.**
**425 De Maisonneuve Blvd. West – Suite 1500**
**Montreal, Quebec H3A 3G5**
**Toll-free telephone 1-800-361-7653**

** There are time limitations on submitting claims. Claims must be submitted within six (6) months following the date of treatment. For cancelled policies, claims must be submitted within sixty (60) days of cancellation of the contract.