

# CLAIM FORM

PREVENTIVE CARE (VIP Plan only) – 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: \_\_\_\_\_

## PREVENTIVE CARE - VIP PLAN ONLY **(TO BE COMPLETED BY YOUR VETERINARIAN)**

Indicate the type of preventive care provided.

Description of care	Cost	Date
<input type="checkbox"/> General exam		
<input type="checkbox"/> Vaccination		
<input type="checkbox"/> Blood profile		
<input type="checkbox"/> Urinalysis		
<input type="checkbox"/> Faecal testing or routine de-worming		
<input type="checkbox"/> Heartworm screening		
<input type="checkbox"/> Preventive treatment for heartworm (maximum 6 months)		
<input type="checkbox"/> Preventive treatment for external parasites or program (maximum 6 months)		
<input type="checkbox"/> Sterilization		
<input type="checkbox"/> Micro-chip		
<input type="checkbox"/> Removal of dewclaws		
<input type="checkbox"/> Dental cleaning		
<input type="checkbox"/> Other (please provide details):		

## DECLARATION OF THE VETERINARY CLINIC **(TO BE COMPLETED BY YOUR VETERINARIAN)**

I declare that I have verified the information regarding this claim and I declare that it is true to the best of my knowledge.

Name of veterinarian: \_\_\_\_\_

Signature of the veterinarian: \_\_\_\_\_

Date : \_\_\_\_/\_\_\_\_/\_\_\_\_

Stamp or name of clinic

## 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 understand that I am responsible for full payment of my veterinarian's fees for all treatment and I confirm that the cost of treatment has been paid in full. I authorize my veterinarian to send my pet's medical file to Optimum Insurance Company Inc. and/or to discuss any treatment and coverage with their claims department. I declare that this claim is made in good faith. All fraudulent claims will result in cancellation of the claim and of the policy.

Signature of policy owner

Date

Please attach original invoices of treatment

## HOW TO MAKE A CLAIM

STEP 1 – Be sure to use the appropriate claim form for the type of claim that you are making. 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 – Bring your pet to your veterinarian so that he may make a diagnosis and begin treatment. Do not forget to bring the form with you because it must be completed and signed by the veterinarian.

STEP 3 – You must pay the veterinarian the complete amount for all treatment. Ask him to complete and sign the form in the appropriate sections.

STEP 4 – Complete and sign the form where indicated.

STEP 5 – Attach the original invoices to the completed and signed form. **KEEP COPIES FOR YOUR FILES.**

STEP 6 – Mail the form and invoices to the following address:



**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.