CLAIM FORM

SICKNESS, ACCIDENT AND DENTAL CARE – Griffe Santé Pet Insurance

Griffesanté Pet Care 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:

SICKNESS, INJURY OR DENTAL CARE *(TO BE COMPLETED BY YOUR VETERINARIAN)*

Indicate the nature of the sickness, injuries or dental care provided. If it is not possible to confirm a diagnosis at this time then please indicate the symptoms and/or the probable diagnosis.

Description of the sickness, injury or dental condition	AMVQ Treatment Code	Treatment	Date that the first symptoms appeared
1)			
2)			
3)			

Did the animal die or was he euthanized because of this sickness or injury? Yes ❒ No ❒
If Yes, please indicate the date of death: _____/_____/_____

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

1. How long have you been treating this animal for the sickness, injury or dental treatment? (D-M-Y): ____-____-_____

2. Is the animal's vaccination programme up-to-date? Yes ❒ No ❒
   If not, what is the date of the last vaccination? (D-M-Y): ____-_____-____

3. Did you do a general health examination of the animal? Yes ❒ No ❒
   If not, when was the last general health examination done? (D-M-Y): ____-____-____

4. Is the treatment, diagnosis, medication directly or indirectly associated with:
   a) For cats, FIP, Chez le chat, le PIF, FIV or FeLV — Yes ❒ No ❒
   b) For dogs, le DEMODEX — Yes ❒ No ❒
   c) Cruciate ligaments, hip dysplasia or luxation of the patella — Yes ❒ No ❒
   d) Sicknesses of the muscular-skeletal system — Yes ❒ No ❒
   e) Vaccination, nail cutting or anal gland expression — Yes ❒ No ❒
   f) For dogs, distemper, bordetella, contagious hepatitis — Yes ❒ No ❒
   g) For dogs, leptospirosis, canine parvovirus disease or rabies — Yes ❒ No ❒

h) For cats, feline distemper, coryza, calicivirus	Yes ❒ No ❒
i) For cats, feline leukemia or rabies	Yes ❒ No ❒
j) Constitutional anomaly, congenital pathology and/or hereditary	Yes ❒ No ❒
k) Screening and preventive treatment against external parasites	Yes ❒ No ❒
l) Orthodontics or extraction of milk teeth	Yes ❒ No ❒
m) Cesarian, monitoring gestation, whelping, abortion, artificial insemination	Yes ❒ No ❒
n) Umbilical or inguinal hernia	Yes ❒ No ❒
o) Clipping or correction of the ears or tail	Yes ❒ No ❒
p) Oophorectomy or castration before the animal is 4 years old	Yes ❒ No ❒
q) Medication for behavioural problems	Yes ❒ No ❒

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 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.

_____ Policy Owner's Signature

_____ 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.

STEP4 – 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:

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.