



Please complete this form in full to claim your benefits. All claims must be made within 13 weeks of the date on your receipt.

A – Plan holder details and confirmation if spouse/partner is claiming

Surname

Forenames

Address

Postcode

Health Cash Plan No

Email Telephone

Claimants details (if different)

Please tick SPOUSE/PARTNER Name

B – Nature of claim

Please tick the appropriate box to indicate the nature of the claim(s).

1. Dental 2. Optical 3. Hearing aids
 4. Osteopathy Chiropractic Acupuncture Homeopathy

Receipts enclosed totalling £ Date of oldest receipt dd / mm / yyyy

C – Hospital in-patient and day surgery benefit

Please complete only if you are claiming hospital in-patient or day surgery benefit

Name of person who received treatment

Was a patient in (name of hospital) Ward No.

Details of admission (please tick as appropriate) General Accident Day Surgery

Please provide full details

Stayed in hospital from dd / mm / yyyy to dd / mm / yyyy

Please give details of any time out of hospital during the above dates:

from dd / mm / yyyy to dd / mm / yyyy from dd / mm / yyyy to dd / mm / yyyy

To be completed by the hospital

We hereby certify that the above information is correct

Specialty

Unit No. Position

Signed Date dd / mm / yyyy

Hospital stamp

D – payment details

We pay your claim by Direct Credit into the bank account that funds your premiums. If you would like this claim paid into an account that is different to the one that funds your premiums, please insert your bank/building society account details below**.

Name(s) of Account Holder(s)

Branch Sort Code Bank / Building Society Account Number

E – Plan holder declaration

I wish to make a claim for the benefit(s) stated and confirm I am eligible to claim.

Signed Date

How to claim benefits

PLEASE ATTACH ALL RELEVANT ORIGINAL RECEIPTS WITH YOUR COMPLETED CLAIM FORM. ALL CLAIMS MUST BE SUBMITTED WITHIN 13 WEEKS OF RECEIPT DATE, UNLESS STATED OTHERWISE.

We cannot accept liability for any charges incurred in the completion of claim forms or provision of medical certificates.

A – Plan holder details and confirmation if spouse/partner is claiming

Complete the details of the plan holder and claimant details if different.

B – Nature of claim

Under 'Benefit Type' complete the type of benefit you are claiming for i.e. Optical. Then complete the amount and the date of your receipt for each benefit claim.

C – Hospital in-patient and day surgery benefit

This section must be completed if you or your partner were patients and you are claiming hospital in-patient or day surgery benefit. You will also need the hospital to complete and certify that the details you have provided are correct.

D – Payment details

All benefits will be paid by Direct Credit.

**Payments paid by Direct Credit will be paid directly into the bank account you use for your monthly premiums unless you have requested a different account in section D. Please note we can only pay your claim into an account other than the account from which premiums are funded if it is an account in your name or a jointly held bank account.

E – Plan holder declaration

Please read and sign the declaration. If we receive your form without a signed Declaration then we will be unable to pay your claim.

Benefit types

Optical

Please send in the completed claim form with the **original** receipt showing the amount paid and the claimant's name. For optical continuing supply scheme payments please see Benefit Rules in the Important Information Booklet.

Dental

Please send in the completed claim form with the **original** receipt showing the amount paid and the claimant's name. The receipt must also show the name and address of the Dentist/Dental Practice.

Complementary therapy

Complementary therapy covers osteopathy, chiropractic, homeopathy and acupuncture treatments. Please send in the completed claim form with the **original** receipt showing the amount charged. Each visit and the amount paid must be shown separately on your receipt.

Hearing aids

Please send the completed claim form with the **original** receipt showing the amount charged.

Hospital in-patient and day surgery

Please complete Part C overleaf to claim under this benefit. A separate claim form must be completed for each hospital in which you or your partner were patients.



If you have any questions, please call **0845 052 5736[†]**



Visit **www.benendencashplan.org.uk**

Once you have completed the claim form, please return it with the required supporting information to:

Claims Department, Benenden Health Cash Plan 66+, PO Box 742, Harrogate, HG1 9PQ

[†] Calls may be recorded for security and training purposes. Calls cost a maximum of 4p per minute for BT customers. The price of calls from non-BT lines will vary. Lines open: Monday-Friday 8am-8pm, Saturday 9am-4pm.

The Benenden Health Cash Plan 66+ is a trading name of the Friendly Healthcare Organisation Limited, Company No. 4114359 registered in England, which is a wholly owned subsidiary of the Benenden Healthcare Society Limited. Registered Office: Holgate Park Drive, York, YO26 4GG. The Friendly Healthcare Organisation Limited is an Appointed Representative of Engage Mutual Health (EMH), which is authorised and regulated by the Financial Services Authority. EMH's FSA Register Number is 202311. You can check this on the FSA's Register by visiting the FSA's website www.fsa.gov.uk/register/home.do or by contacting the FSA on 0845 606 1234. Engage Mutual Health is the provider and administrator of this plan. Their contact address is Engage Mutual Health, Hornbeam Park Avenue, Harrogate, HG2 8XE.

The Benenden Health Cash Plan 66+ is available only to Benenden Healthcare Society members. No advice has been given. If you are in doubt as to the suitability of this product you should seek independent advice.



Benenden
Health Cash Plan **66+**