

# Claim Form

Policy # **CB** \_\_\_\_\_

**Policyholder Checklist:**

- Review Policy Documents and Terms and Conditions to see if coverage is available for the current condition being claimed
- Detailed invoices for condition(s) being claimed are attached
- Claim form is **fully** completed & signed by both you and your veterinarian
- Complete medical history is attached if not previously submitted

**Part 1 – To be completed by the policyholder** (please print)

*Please refer to your Policy Terms and Conditions for the time limitation on submitting claims.*

Policyholder: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Prov: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

**Please tick if there has been a change of address:**

Pet's Name: \_\_\_\_\_ Species: \_\_\_\_\_

Sex:  Male  Female Age: \_\_\_\_\_ Breed: \_\_\_\_\_

*To the best of my knowledge, the following statements are true in every respect and I have abided by all of the Policy Terms and Conditions. I understand that any misrepresentation or omission of any material fact can result in denial of the claim.*

Signature of Policyholder: X \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yy)

**Part 2 – To be completed by the Veterinary Clinic ONLY**

*Please list the medical Illness/Accident for which the policyholder is making a claim:* \_\_\_\_\_

Date accident occurred or symptoms of illness were first noted: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yy)

Has this pet received treatment for this Illness/Accident in the past?  Yes  No

If YES, when? : \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yy)

Was this accident or illness fatal?  Yes  No

***If claiming for Accidental Death Benefits, please include a statement from a witness or attending veterinarian and a receipt for the original purchase price of the pet. Please refer to the Policy Terms and Conditions for further details.***

Has this pet had an annual physical examination in the past 12 months, and up to date on all recommended vaccinations?  Yes  No

How long has this pet been a client of your clinic?  Less than 18 months  More than 18 months

*I confirm that to the best of my knowledge, the above statements are true in every respect.*

Signature of Attending Veterinarian: X \_\_\_\_\_ D.V.M. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(mm/ dd/ yy)

Name of Veterinarian: \_\_\_\_\_

Practice Stamp

Please forward completed forms to:  
CherryBlue Pet Insurance Programs  
710 Dorval Drive, Suite 400  
Oakville, Ontario L6K 3V7

Toll Free: 1-866-DOG-BLUE (364-2583)  
Fax: 1-866-369-PETS (7387)  
www.cherryblue.ca

**Reminder! A healthy pet is a happy pet and to ensure that your insurance policy remains in force, your pet must receive an annual physical exam by the licensed Veterinarian of your choice.**