

Verify <input type="checkbox"/>	Optical <input type="checkbox"/>	Dental <input type="checkbox"/>	for office use only
Notes			
			D/C
			CHQ

## Claim form - Foresight

### Part 1

Westfield Account No.	<input type="text"/>	Date of Birth	DAY <input type="text"/>	MONTH <input type="text"/>	YEAR <input type="text"/>
Surname	<input type="text"/>	Please place a cross in this box if this is a change of address <input type="checkbox"/>			
First Name	<input type="text"/>				
House Number/Name	<input type="text"/>				
Street	<input type="text"/>				
Town	<input type="text"/>	Postcode	<input type="text"/>	<input type="text"/>	<input type="text"/>
Contact Tel No.	<input type="text"/>	Please place a cross in this box to receive payment advice via email <input type="checkbox"/>			
Email address	<input type="text"/>				

If you wish your payment to be paid directly into the bank, then please enter your account details. We can only credit an account that is held in your name. If you have already provided these details then there is no need to fill them in again unless your account details have altered.

Account No.	<input type="text"/>	Sort Code	<input type="text"/>
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#### Preferences

We may occasionally use your contact information to contact you by post, email, text or phone with marketing offers and details of our other products and services. We may also share all contact details with other selected organisations who may contact you by post or phone about other products and services. To opt out please contact us at the above address. If you are also happy to receive emails/texts from these other selected organisations please contact us at the above address.

Please fill in this section if the claim is for your dependent child.

**Please note: This is only available if your Plan covers children's benefits.**

Child's Surname	<input type="text"/>	Date of Birth	DAY <input type="text"/>	MONTH <input type="text"/>	YEAR <input type="text"/>
Child's First Name	<input type="text"/>	Is the dependant resident with the policyholder? Yes <input type="checkbox"/> No <input type="checkbox"/>			

### Declaration and Signature

Westfield Contributory Health Scheme Ltd. will only pay a proportionate share of any claim if you have other health insurance in place. If you have another insurance policy that may cover this claim, please tick to say whether or not you intend to claim on that insurance policy. If you tick Yes, please provide full details of the other insurance provider and the amount being claimed.

Yes ☐ No ☐

#### Fraudulent Claims / Fair Processing Notice

In the interest of all of our customers, detection of fraudulent claims may result in legal action being taken, immediate cancellation of your policy and all benefit rights. We may also seek to recover any monies paid to you that were not due under the Terms and Conditions of this policy. For audit purposes we will carry out checks on the information you and practitioners provide to us, this may include Sensitive Personal Data such as data relating to health and medical conditions. For the detection and prevention of fraud we may share this information with other insurance providers; selected third parties; police and other enforcement agencies; and the employer (if they are paying some or all of the premium for your cover) where we have a reasonable belief that the claims activity is in serious breach of our terms and conditions and/ or may be fraudulent.

I declare that the information shown on this form and any accompanying documentation is true and complete. I will give you any proof or further information you ask for. I authorise any medical practitioner or other person(s) concerned with providing health care to give you any information relevant to this claim and or my policy. Where I have provided information about another person I have obtained their consent to do so.

Policyholder's Signature <input checked="" type="checkbox"/>	Date	DAY <input type="text"/>	MONTH <input type="text"/>	YEAR <input type="text"/>
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### Part 2. Please place a cross in the box showing the benefit you are claiming.

Please enclose the relevant original receipted account clearly showing the name, address and qualifications of the practitioner. We will not accept visa/debit card receipts or photocopies.

Optical benefit	(YOU) <input type="checkbox"/>	(DEPENDENT CHILD) <input type="checkbox"/>	£ <input type="text"/>	Date of receipt	DAY <input type="text"/>	MONTH <input type="text"/>	YEAR <input type="text"/>
Please enclose the receipt and say how much you paid							
Dental benefit	(YOU) <input type="checkbox"/>	(DEPENDENT CHILD) <input type="checkbox"/>	£ <input type="text"/>	Date of receipt	DAY <input type="text"/>	MONTH <input type="text"/>	YEAR <input type="text"/>
Please enclose the receipt and say how much you paid							
Dental Trauma	(YOU) <input type="checkbox"/>	(DEPENDENT CHILD) <input type="checkbox"/>	£ <input type="text"/>	Date of receipt	DAY <input type="text"/>	MONTH <input type="text"/>	YEAR <input type="text"/>
Please enclose the receipt and say how much you paid							
For all claims in this section your receipt should clearly show the practitioners name and qualifications.							
Physiotherapy	(YOU) <input type="checkbox"/>	(DEPENDENT CHILD) <input type="checkbox"/>	Acupuncture	(YOU) <input type="checkbox"/>	(DEPENDENT CHILD) <input type="checkbox"/>	Osteopathy	(YOU) <input type="checkbox"/>
Chiropractic	(YOU) <input type="checkbox"/>	(DEPENDENT CHILD) <input type="checkbox"/>	Chiropractic	(YOU) <input type="checkbox"/>	(DEPENDENT CHILD) <input type="checkbox"/>	Consultation*	(YOU) <input type="checkbox"/>
Please enclose the receipt and say how much you paid £ <input type="text"/>							
Date of receipt DAY <input type="text"/> MONTH <input type="text"/> YEAR <input type="text"/>							
*You <u>must</u> name the Doctor who recommended the consultation <input type="text"/>							

We will only pay benefit under the General Terms and Conditions and Benefit Rules shown in our current leaflet.

We must receive claims within 13 weeks of the date of each receipt.

If any documentation submitted is found to be untrue, this may lead to the termination of your policy.

# DID YOU KNOW?

You may be able to UPGRADE  
your cover or apply for  
PARTNER cover too....

See General Terms and Conditions in your  
plan leaflet for further details.

**Or call the Customer Helpline on:**

**0114 250 2000**

**Available from 8am - 6pm**

**Monday to Friday**

**(except Christmas Eve & Public Holidays)**