How to claim in 2 easy steps

Step 1: Please complete the claim form on the following page.

Step 2: Send the form with all necessary documentation via email to **claims.au@petcovergroup.com**. To expedite your claim, we recommend sending us all documents electronically.

Claim checklist

Please ensure the policyholder completes sections 1-5 and then pass to your doctor or dentist to complete the final part where indicated.

Before sending in your claim form, please ensure the following:

- ☐ You and the doctor/dentist have fully completed all sections of the claim form
- ☐ You have attached the required documentation, including original invoices

Note: We reserve the right to request additional information or original documents for submitted claims. We will advise you if we need this once we receive your claim form.

Tip: Should you not have access to a scanner then we are happy for you to simply take a picture with your mobile phone camera or ask your doctor/dentist to directly send to us the invoice(s) and supporting document(s) via email. All documents need to be submitted in a legible resolution.

How your claim will be paid

- If you have elected to pay your premium by direct debit, your benefits will be paid directly into your nominated bank account.
- If you pay your policy other than by Direct Debit, please add your bank account details in the payment options section on this claim form.
- If you want us to pay the injured person, please nominate this in in Section 5. Payment and declaration. Please note, this option is only available, if all parties involved consent to this payment option.

Contact us

If you have any questions about your claim
please call us on 1300 731 324
(between 8:30 - 17:00 Mon - Fri)
or email us at claims.au@petcovergroup.com

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Horse Personal Accident Claim Form

Petcover®

Claim received on
(Petcover use only):

Please complete the claim form and forward to us with the relevant documents to claims.au@petcovergroup.com
The policyholder is to complete the sections in blue and the medical/dental practitioner is to complete the section in red

Section 1. Your details

Policy no. :

Policyholder's first name:

Policyholder's surname:

Policyholder's address:

Contact no. :

Email:

Postcode:

Section 2. Horse details

Horse's name:

Do you own this horse? Yes: ☐ No: ☐

If no, please provide the owner's details

Owner's name:

Owner's address:

Owner's contact no.:

Email:

Postcode:

Section 3. Accident details

Please give details of the person injured:

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐

Surname:

First name:

Address:

Postcode:

Date of birth:

Occupation:

Was the injured person: Riding the horse ☐
Leading the horse ☐
Handling the horse ☐

Date of accident:

For what purpose was the animal being used at the time the accident occurred?

Please give full details of the injuries:
Continue on a separate sheet if necessary

How did the accident happen:
Continue on a separate sheet if necessary

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Was the injured person wearing an approved riding helmet at the time the accident occurred? Yes: ☐ No: ☐

If yes, please provide AS/NZS (or equivalent) number: _____

Section 4. Claim details

Please select below which benefits detailed you are claiming for under the section:
Your Certificate of Insurance will confirm if you have Core or Premium cover under the section

	Core	Premium	
Death	$20,000	$40,000	☐
Permanent blindness in one or both eyes	$20,000	$40,000	☐
Loss of one or both hands or arms Meaning physical severance at or above the wrist or ankle or the total and permanent loss of use of an entire hand, arm, foot or leg	$20,000	$40,000	☐
Loss of one or both feet or legs Meaning physical severance at or above the wrist or ankle or the total and permanent loss of use of an entire hand, arm, foot or leg	$20,000	$40,000	☐
Permanent total disability Due to an accident, which results in you never being able to carry out any type of work	$20,000	$40,000	☐
Temporary total disability Due to an accident, which results in you being unable to carry out all the duties of your job	Not covered	$250 each week	☐
Emergency dental treatment	$2,000	$2,000	☐
Hospitalisation	$30 for each 24 hours you are in hospital	$30 for each 24 hours you are in hospital	☐

Do you wish to have the claim settlement made payable to the injured person? Yes: ☐ No: ☐

For dental claims only, please state the amount you are claiming : _____

Section 5. Payment and declaration

Payment can be made out to the injured person. If this is not the policyholder, please sign as authorisation to do so.

Signature _____

Print name: _____

Date: _____

Claim payments are made by electronic payment transfer. If the claimant is the policyholder, the claim will be paid into the bank account your premium is collected from.

If the claimant is not the policyholder, please provide the bank details for the injured person below:

Account holder name: _____ BSB: _____ Account number: _____

Declaration

Privacy: The Privacy Act 2018 requires us to tell you that as an insurer we collect your personal and sensitive information in order to calculate your loss and entitlement, determine our liability, compile data and handle claims. When handling claims, we may disclose your personal and other information to third parties such as other insurers, loss adjusters, external claims data collectors, investigators, the Insurance Reference Service (IRS), etc., or other parties as required by law. You have the right to seek access to your personal information and to collect it at any time. Please contact us via phone or email and advise us of the changes.

We/I certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. We/I understand that deliberate misrepresentation of the animal's condition or the omission of any material facts may result in the denial of the claim and/or cancellation of the policy. We/I understand that policy administrators will assess the claim in accordance with the cover selected and benefits payable by the policy. We/I authorise any veterinary surgeon who has treated our/my pet to provide to the insurer any details they may require. We/I acknowledge that we/I have read and understood the Privacy Act 2018 and consent to the collection, storage, use and disclosure of personal and sensitive information to all persons affected by this claim. Please note that issuance or completion of this form does not acknowledge liability or guarantee payment of the claim.

☐ Please tick here to confirm you have read and acknowledged the above declaration. Date: _____

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Medical/Dental practitioner to complete at the policyholders expense

Injured person's name and address:

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐

Surname:

First name:

Address:

Postcode:

Are you the insured person's usual medical/dental practitioner? Yes: ☐ No: ☐

If Yes, how long have they been attending your practice?

What date did you first attend the injured person for the injuries?

What do you believe to be the cause of the injury?

What is the nature and extent of the injuries sustained?

a) Please state the area of the body affected:

b) Will the injuries give rise to:

i) Permanent blindness in one or both eyes? Yes: ☐ No: ☐

ii) Loss of one or both hands or arms? Yes: ☐ No: ☐

iii) Loss of one or both feet or legs? Yes: ☐ No: ☐

iv) Permanent Total Disablement entirely preventing the injured person from any type of work? Yes: ☐ No: ☐

v) Temporary Total Disablement preventing the injured person from attending to any part of his/her occupation? Yes: ☐ No: ☐

vi) The hospitalisation of the injured person? Yes: ☐ No: ☐

vii) Emergency dental treatment Yes: ☐ No: ☐

If you have answered Yes to the above questions, please give full details:

If you have answered Yes to questions (iv), or (v) above please give the dates from which incapacity/hospitalisation commenced and ended

Start

End

Are there any aspects of the injured person's previous medical/dental history which may have a bearing on this claim? Yes: ☐ No: ☐

Please state the total cost of the injured person's treatment or estimate if treatment not yet concluded (deleting any treatment cost unrelated to the accident)

Has treatment finished? Yes: ☐ No: ☐

Medical/Dental Practitioner details:

Name:

Address:

Provider Number:

Signature

Date:

Doctors/Dental Practice stamp (if applicable)

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