

Saga Health Cash Plan

Claim form

Saga Health Cash Plan, Gamgee House, 2 Darnley Road, Birmingham B16 8TE

Telephone: 0800 027 1343

Please complete in BLOCK CAPITALS

- Sections A, B, C, D and E to be completed by the policyholder
- Section F and/or G, if applicable, to be completed by the hospital
- If Section F or G is to be completed by the hospital, we would advise that you only complete your bank details in Section D after they have returned the form to you
- Please send your claim form to: Saga Health Cash Plan, Gamgee House, 2 Darnley Road, Birmingham B16 8TE

Period for claim submission and settlement

- Claims must be submitted within 13 weeks of the date on the receipts for charges made, or the date of discharge from hospital.
- Most claims are paid within a few working days. Where hospital in-patient benefit or day-case surgery benefit is claimed, please allow 2/3 weeks for settlement.
- Hospital in-patient/day-case surgery claims. Any alteration of dates must be countersigned by the hospital. Any charges payable in respect of the completion of the medical details by the hospital(s) will be the responsibility of the claimant.

A To be completed by the policyholder

Your details

Title

Address

Surname

Forename(s)

Tel No. (in case of query)

Date of birth

B Claimant details

Policy number

This claim is on behalf of:

Myself, the policyholder

My spouse/partner

My child, below age 18

Level of cover:

Level 3

Level 2

Level 1

B Claimant details (continued)

If the claim is for your spouse/partner or child please supply their details below.

Title

Forename(s)

Surname

Date of birth

C Declaration

I declare that I am a policyholder of the Saga Health Cash Plan and that all details given throughout this form are true. I hereby authorise the verification of receipted accounts submitted by me and/or details completed on this form in respect of hospital stays/day-case surgery, should this be necessary.

Signature

Date

Failure to sign this declaration will result in a delay in processing your claim.

D Settlement details

If you are making a claim for hospital treatment, to keep your bank details secure we would advise you not to complete this section until they have completed Section F/G on pages 3-4.

Do you wish to receive your settlement by cheque or directly into your bank account ?

Please tick as appropriate each time you submit a claim.

If directly into your bank account, please complete the following:

Account name

Sort code

 - -

Bank name

Account Number

Bank address

SAGA USE ONLY

E Which benefits are being claimed?

Important: Please remember to enclose all original receipts. We are unable to accept credit/debit card receipts.

Please tick box(es) for the benefit(s) being claimed and, where indicated, state the value of the receipts.

Dental care	<input type="checkbox"/>	£ <input type="text"/>
Optical care	<input type="checkbox"/>	£ <input type="text"/>
Hearing aid	<input type="checkbox"/>	£ <input type="text"/>
Health consultations	<input type="checkbox"/>	£ <input type="text"/>

Therapies:

Osteopathy	<input type="checkbox"/>	£ <input type="text"/>
Chiropody	<input type="checkbox"/>	£ <input type="text"/>
Physiotherapy	<input type="checkbox"/>	£ <input type="text"/>
Chiropractic	<input type="checkbox"/>	£ <input type="text"/>

Complementary Therapies:

Homeopathy	<input type="checkbox"/>	£ <input type="text"/>
Acupuncture	<input type="checkbox"/>	£ <input type="text"/>
Home help/ home nursing	<input type="checkbox"/>	£ <input type="text"/>
Health screening	<input type="checkbox"/>	£ <input type="text"/>
Allergy testing	<input type="checkbox"/>	£ <input type="text"/>
Hospital in-patient	<input type="checkbox"/>	(ensure section F is completed)
Hospital day-case	<input type="checkbox"/>	(ensure section G is completed)

F Hospital in-patient claims

Section F, if applicable, should be completed by the hospital medical records office/ward clerk

I certify that

Title

Surname

Forename(s)

residing at the address in section A?

Yes No

was an INPATIENT of this hospital.

Hospital number

from

(date of admission)

to

(date of discharge)

and from

(date of admission)

to

(date of discharge)

The number of nights' **home leave** nights.
during the period(s) above totalled

In respect of treatment: (please tick)

Acute illness

Accident

Geriatric/elderly rehab

Psychiatric

F Hospital in-patient claims (continued)

Signed

Date of signing

Contact number

Status

HOSPITAL'S OFFICIAL STAMP

G Day-case surgery claim

Section G, if applicable, should be completed by the hospital medical records office/ward clerk

I certify that

Title

Surname

Forename(s)

Address

attended this hospital on

for scheduled DAY SURGERY requiring the use of operating theatre facilities, but did not stay overnight.

The surgery was performed under:

General/local anaesthetic

Sedation

Was the surgery a scope procedure - e.g. Endoscopy?

Yes

No

Signed

Status

Date of signing

Contact number

HOSPITAL'S OFFICIAL STAMP

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Data Protection. Information Saga and the underwriter receive about this claim will become part of the data held by the underwriter in accordance with data protection legislation.

The underwriter will store this information securely, handle it on a confidential basis and use it to process the claim. The information, including the medical detail, will be disclosed to Saga, where it will be stored securely and used for assessment of our business performance, to perform any statistical analysis in order to improve the service, and to cross check any future applications for membership of the scheme. The underwriter may be asked to provide other organisations, such as the Inland Revenue, with information, but the underwriter will not supply information about you to anyone else unless it is a legal requirement, intended to prevent fraud or improper claims, or unless the underwriter has your authorisation.