

# Claim Form for Boarding, Kennel & Cattery Fees



## Important notes

We will pay for the cost of boarding your pet at a licensed kennel, cattery or with someone who is looking after your pet and does not live with you, up to the maximum benefit amount.

Note: Please include RECEIPTS and applicable documentation. Retain copies for your records.

Please see your Policy Terms, Conditions, and Benefits of Insurance documents for full details.


## Mail completed Claim Form to:

Western Financial Insurance Company  
Attn: Claims Dept.  
200 - 1200 Portage Avenue  
Winnipeg, MB R3G 0T5

## 1 About you and your pet (affix a label if you have one)

Policy number: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  Please check if new address  
\_\_\_\_\_  
\_\_\_\_\_  
Home phone: (\_\_\_\_\_) \_\_\_\_\_ Work phone: (\_\_\_\_\_) \_\_\_\_\_  
Fax: (\_\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Pet's name: \_\_\_\_\_  
Date of birth (mm/dd/yy): \_\_\_\_\_  
Gender:  male  female  
Type of pet:  dog  cat  
Breed: \_\_\_\_\_



**Questions? Contact us at:**  
1.800.581.0580 or info@westernfic.com

## 2 To be completed by the insured's General Practitioner or Hospital/Surgeon

Patient's name: \_\_\_\_\_  
Name of admitting hospital: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Reason for hospitalization: \_\_\_\_\_  
\_\_\_\_\_

Hospital admission date: 

mm	dd	yyyy
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 Hospital discharge date: 

mm	dd	yyyy
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Date illness commenced or accident occurred: 

mm	dd	yyyy
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I confirm to the best of my knowledge the above statements are true in every respect.

Signature of healthcare provider: \_\_\_\_\_ 

mm	dd	yyyy
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## 3 To be completed by the boarding kennel or cattery owner/home caregiver

Date of boarding or home care: From: 

mm	dd	yyyy
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 To: 

mm	dd	yyyy
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Boarding fees per day: \$ \_\_\_\_\_ Total fees: \$ \_\_\_\_\_  
I confirm to the best of my knowledge the above statements are true in every respect.  
Name of Kennel or Cattery: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Signature of Kennel/Cattery owner/homecare giver: \_\_\_\_\_ 

mm	dd	yyyy
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## Checklist

**Have you:**

- Completed sections 1 & 4
- Signed this form
- Attached detailed receipts

**Has your healthcare provider:**

- Completed section 2
- Signed this form

**Has your pet's caregiver:**

- Completed section 3
- Signed this form

## 4 Policyholder declaration

I understand that the fees listed may not be covered, or may exceed my plan benefits. I understand that I am financially responsible for the entire amount, and confirm that amount has been paid in full. I declare that I have fulfilled the conditions of the Document of Insurance and the Policy Terms, Conditions, and Benefits of Insurance documents.

Signature of policyholder: \_\_\_\_\_ 

mm	dd	yyyy
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### Internal use only

Client number:	Plan:	Checklist number:	Date received:
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