ANTILLES INSURANCE

PET INSURANCE

CLAIM FORM

Questions: Please call us at 787-777-1636 or email us at petclaims@cuvroinsurance.com

1. **Complete The Claim Form –** please complete all information and remember to sign and date the claim form.
2. **Send Us Your Claim Form and Itemized Invoice** – to help us process your claim quickly, fill out the form in your online profile or email or fax your claim form, itemized veterinary bill, along with pet's medical record if this is your first claim. **We are unable to process your claim without your pet's medical records.**
3. **The Antilles Insurance claims team will then process your claim as quickly as possible** – our goal is to process all claims within 72 hours.

Section A – Member Information

Policy Number **Policy Start Date**		**Pet Name**	**Pet Age**
Pet Parent Name		**Pet Gender** ☐ Male ☐ Female	**Pet Breed**
Complete Address Street Address City Province / State Zip		**Contact Number**	**Email Address**

Section B – Claim Details

Have you submitted a claim for this illness/injury previously?

☐ **YES** [please indicate date(s) of veterinary visit(s)]

Date _____ Date _____

Date _____ Date _____

☐ **NO** [please indicate date when pet first experience the symptom of illness or injury]

Date _____ Date _____

Date _____ Date _____

Reason for visit, please check all that apply:

☐ **Preventive Care** (ex. annual exam, vaccination)

☐ **Accident** (please indicate diagnosis)

☐ **Illness** (please indicate diagnosis below)

Diagnosis or Injury indicated by Veterinarian

Name of Veterinary Clinic or Hospital

PLEASE SUBMIT YOUR CLAIM BY EMAIL AT PETCLAIMS@CUVROINSURANCE.COM

Section C – Itemized Procedure and Expense Details

Date of Visit	Treatment or Procedure	Invoice Number	Amount ($)

Invoice Total

You must send itemized invoices with your claim form. Please do not send estimates.	**$**

Section D – Remittance Details

Beneficiary Name	**Account Number**	**Transfer Routing Number (Wire / ACH)**
Bank Name	**Beneficiary Mailing Address**	

Section E – Member Signature & Date

X (SIGNATURE)	**DATE** (MM/DD/YYYY)	**By signing this claim form, I confirm to the best of my knowledge the information I have provided is true and correct. I authorize the release of my pet's medical records to Antilles Insurance.**

PLEASE SUBMIT YOUR CLAIM BY EMAIL AT PETCLAIMS@CUVROINSURANCE.COM