Claim Form - Optical/Dental

Sheffield Mutual Est. 1892
For you, your family, your future

All information given will be treated in the strictest confidence.
The policyholder (or proposer of the policy if the policyholder is a child) should complete the appropriate sections in **BLOCK CAPITALS** using black or blue ink only. You can claim for one or both benefits on this form. Once completed, please return it to us at the address overleaf.

Claim Type: Optical ☐ Dental ☐

1. Members Details

Title: Forename(s): Surname:

Policy Number(s):

Address:

Postcode:

2. Opticians Address

Postcode:

3. Dentists Address

Postcode:

Total Cost : £

I have provided/enclosed a copy of the receipt(s) which is(are) dated within the last three months: ☐

Signature:

Date: D D / M M / Y Y Y Y

4. Payment

Please send my payment by cheque ☐

OR

If you would like your bank account to be credited with the payment please complete the details below (this must be an account in the policyholders name):

Bank Name and Address:

Account Name:

Sort Code:

Account No.:

www.sheffieldmutual.com

Online chat available

Call our team

01226 741 000

Calls may be monitored and recorded for your protection.

Opening hours: 9am-5pm Mon-Fri

Email us

enquiries@sheffieldmutual.com

@SheffieldMutual

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For Office Use Only

Date received: D D / M M / Y Y Y Y

Date of last claim Optical: D D / M M / Y Y Y Y

Amount of claim: £

Date of last claim Dental: D D / M M / Y Y Y Y

Notes:

Signature:

Cheque Number/ Bank Payment:

Date: D D / M M / Y Y Y Y