



# Optical/dental/hearing claim form



All information given will be treated in the strictest confidence. The policyholder (or proposer if the policyholder is a child) should complete the appropriate sections in **BLOCK CAPITALS**. Once completed, please return it to us at the address below.

## 1. Your details

|                      |                      |                                                                                                                                                                                   |
|----------------------|----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Title:               | Forename(s):         | Surname:                                                                                                                                                                          |
| <input type="text"/> | <input type="text"/> | <input type="text"/>                                                                                                                                                              |
| Address:             |                      | Policy number(s):                                                                                                                                                                 |
| <input type="text"/> |                      | <input type="text"/>                                                                                                                                                              |
|                      |                      | Postcode: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |

I have provided/enclosed a copy of the practice receipt(s) dated this calendar year. Claims for the previous year can be made up until 31 January. Receipt must be in the name of the policyholder.

☐

## 2. Payment

Please choose one option below:

☐ 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 policyholder or proposer's name):

|                               |                                                                                                                                                                         |
|-------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Name(s) of account holder(s): | Bank sort code:                                                                                                                                                         |
| <input type="text"/>          | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>                                           |
| <input type="text"/>          | Account number:                                                                                                                                                         |
|                               | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |

☐ Pay the funds into my ISA policy held with Sheffield Mutual (this must be in the name of the claimant). This will count towards your annual subscription allowance. If you are wishing to pay into a Junior ISA policy, please enter the policy number below.

ISA/JISA Policy number:

☐ Donate to our chosen 'Charity of the Year' as selected by Sheffield Mutual and shown on our website. [www.sheffieldmutual.com/about-us/charity-and-sponsorship/](http://www.sheffieldmutual.com/about-us/charity-and-sponsorship/)

Signature:  Date:  /  /

For office use only



[www.sheffieldmutual.com](http://www.sheffieldmutual.com)



[enquiries@sheffieldmutual.com](mailto:enquiries@sheffieldmutual.com)



Call our team on **01226 741 000**

Calls may be monitored and recorded for your protection

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