insurance

redefining / standards

Insurance Claim Form

Notification of loss under insurance of costs of medical treatment and life-saving while abroad

For the purpose of quick and efficient examination of the claim, please complete the form below accurately and send directly to the address of the loss adjuster acting on behalf of AXA TUiR S.A.

Please attach the following to the form:
1. original bills for the costs incurred
2. a photocopy of your identity document (identity card or passport)
3. medical documentation, including medical diagnosis and other documents stating the reasons for and scope of medical assistance

Correspondence address:

Inter Partner Assistance Polska S.A.
ul. Chłodna 51
00-867 Warszawa
tel. +48 22 575 90 80

A. GENERAL INFORMATION

1. **Name and surname of the claimant** (or legal guardian)

2. Contact tel. no. ⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌋

3. **Name and surname of the insured person**

4. Address

Town/City _____ Post code ⌊_⌊_-⌊_⌊_⌊ Street _____ House number/flat number ⌊_⌊_⌊_/⌊_⌊_⌊

Contact tel. no. ⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌋

5. Correspondence address

Town/City _____ Post code ⌊_⌊_-⌊_⌊_⌊ Street _____ House number/flat number ⌊_⌊_⌊_/⌊_⌊_⌊

6. E-mail address

Do you consent to correspondence being sent to you by e-mail? ☐ yes ☐ no

7. PESEL personal electronic identity number* ⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌋

8. Number of the Beneficiary's bank account to which indemnity should be paid ⌊_⌋

9. Name of the bank

10. Name and surname of the account holder

11. Instructions on the method of payment of indemnity ☐ postal order *(please state the residence address if different from the one given above)*

Town/City _____ Post code ⌊_⌊_-⌊_⌊_⌊ Street _____ House number/flat number ⌊_⌊_⌊_/⌊_⌊_⌊

12. Policy number/travel reservation number

13. Date and place where the policy was taken out (applies to individual policies)

14. Name of the travel agent – travel organizer (applies to group policies under agreements with tour operators)

B. TRAVEL INFORMATION

1. Country where the event occurred

2. Beginning of travel
departure date ⌊D_D_⌊_⌊M_M_⌊_⌊Y_Y_Y_Y_⌋ time ⌊H_H_⌊_⌊M_M_⌋

3. End of travel
departure date ⌊D_D_⌊_⌊M_M_⌊_⌊Y_Y_Y_Y_⌋ time ⌊H_H_⌊_⌊M_M_⌋

C. INFORMATION ON LOSS OR DAMAGE

1. Date of falling sick/ accident D D M M Y Y Y Y time H H M M

2. Was the emergency centre of Inter Partner Assistance Polska S.A. informed of the occurrence? ☐ yes ☐ no
If not, why not?

D. DESCRIPTION OF THE EVENT

1. Please tick the appropriate box and describe the occurrence: ☐ sudden illness ☐ accident

2. Since when has the Insured suffered from the ailments and when was medical advice first given in that respect?

3. Name and surname of the doctor and address of the medical centre in Poland where the Insured was treated

Authorisation for Medical Centres

I, the undersigned _____

resident at _____

hereby authorise all doctors, hospitals and other healthcare centres as well as social insurance centres or persons who hold my personal data and my medical records to provide, at any time, at the request if INTER PARTNER ASSISTANCE, all and complete information on the history of my illness, information on illnesses that I have had, the state of my physical and mental health, any hospitalisation, medical examinations or diagnoses and treatment. In this respect, I release the doctors from their doctor – patient privilege.

D D M M Y Y Y Y _____
Date and signature of the Insured or legal guardian (if the Insured is a minor)

4. Were there any witnesses to the accident? ☐ yes ☐ no
If so, please state the names and addresses of persons participating in the accident or witnesses:

5. Was the Insured under the influence of alcohol at the time of the event? ☐ yes ☐ no

6. Was the Insured under the influence of narcotics at the time of the event? ☐ yes ☐ no

E. INFORMATION ON THE COSTS INCURRED

Please provide a list of all the costs incurred.

Expenses will be refunded on condition that the original receipts for the costs incurred are presented
(if the space below is insufficient, please continue on a separate sheet).

Description of the bill *(e.g. drugs, medical consultation, transport)*	**Receipt issued on:**	**Amount and currency**	**Paid****
1)	D D M M Y Y Y Y		☐ yes ☐ no
2)	D D M M Y Y Y Y		☐ yes ☐ no
3)	D D M M Y Y Y Y		☐ yes ☐ no
4)	D D M M Y Y Y Y		☐ yes ☐ no
5)	D D M M Y Y Y Y		☐ yes ☐ no

*** If the bill was paid, place state who paid it:*

F. INFORMATION ON OTHER INSURER

1. Does the Insured have another policy covering the scope of medical treatment/life-saving costs? ☐ yes ☐ no
If so, please state the name of the company, address and policy number:

2. Does the Insured have a bank card offering insurance for the costs of medical treatment? ☐ yes ☐ no
If so, please state the name of the bank, address and card number:

G. DECLARATIONS

I acknowledge that my personal data will be processed by AXA TUiR S.A. with its registered office in Warsaw, for the purpose of adjusting the loss being claimed.

I authorise the Company to acquire any medical information, save for results of genetic examinations, concerning the state of my health, from any doctor who has treated me or provided me with medical advice, and also in all medical centres and healthcare institutions where I received medical assistance. Further, I agree to any information on the state of my health being made available to the Company by doctors, medical centres and healthcare institutions.

I authorise the Company to obtain information in court, at the public prosecutor's office, and from the police and other bodies and institutions in connection with the accident or event that is the basis for establishing the Company's liability.

D D M M Y Y Y Y

Date _____ Signature of the Insured or attorney-in-fact

I hereby confirm that the information given above is true and I am aware that certifying an untruth or giving false information may result in my being held criminally liable and may result in a refusal to pay indemnity.

D D M M Y Y Y Y

Date _____ Signature of the person reporting the loss

We wish to inform you that providing your personal data is voluntary but necessary for the insurance contract to be implemented and the claim to be examined (the sole purpose – data processing). The data administrator is AXA Towarzystwo Ubezpieczeń i Reasekuracji S.A. with its registered office in Warsaw, 00-867, ul. Chłodna 51. The data subject is authorised to inspect and amend his/her personal data and to lodge a written and substantiated demand that his/her personal data no longer be processed in light of his/her special situation, and to object to the processing of his/her personal data.

If you need help in filling in this form, please call +48 22 575 90 80 or write to axa-likwidacja.szkoda@ipa.com.pl.

* Applies to Polish citizens only.