insurance

redefining / standards

Insurance Claim Form

Notification of loss under accident insurance

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. medical documentation confirming the treatment (or first aid after the accident), including a description of bodily injury and medical diagnosis, and medical tests results and medical documentation on the continuation of treatment after the accident, together with results of tests
2. a doctor's certificate that the treatment is completed
3. a death certificate (if applicable)
4. a police report, if the accident was caused by a traffic accident
5. testimonies of witnesses
6. a photocopy of your identity document (identity card or passport)
7. a photocopy of the vehicle registration document and the driving licence (if applicable)

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**

Address

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

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

4. Correspondence address

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

5. E-mail address

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

6. PESEL personal electronic identity number* ⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊_⌊

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

8. Name of the bank

9. Name and surname of the account holder

10. 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 ⌊_⌊_⌊_/⌊_⌊_⌊

11. Policy number/travel reservation number

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

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

B. TRAVEL INFORMATION

1. Time of travel

From ⌊D⌊D⌊_⌊M⌊M⌊_⌊Y⌊Y⌊Y⌊Y⌋ until ⌊D⌊D⌊_⌊M⌊M⌊_⌊Y⌊Y⌊Y⌊Y⌋ Country _____

C. INFORMATION ON THE ACCIDENT

1. Date of the accident D D M M Y Y Y Y time H H M M

2. Place of the accident

3. Circumstances of the accident
Please give a detailed account of the event and the circumstances (if the injury was caused while playing sport, please state which discipline)

4. Description of injuries

5. Address of the centre in Poland where the customer was treated after the accident

6. Was the treatment completed? *If so, please state when.* ☐ yes ☐ no

7. Were the police/ambulance service/other institutions *(state names and addresses)* notified of the accident?

8. Was the accident notified to Inter Partner Assistance? ☐ yes ☐ no

9. Was the Insured (perpetrator) under the influence of narcotics? ☐ yes ☐ no

10. Was the Insured (perpetrator) under the influence of alcohol? ☐ yes ☐ no

11. Did the Insured have a blood test? ☐ yes ☐ no

D. PLEASE FILL IN THE PART BELOW ONLY IF THE INJURY WAS CAUSED BY A TRAFFIC ACCIDENT

1. Type of vehicle by which the Insured was travelling (a passenger car, a bus, etc.)

2. Was the Insured driving the vehicle? ☐ yes ☐ no

3. If so, did the Insured hold an appropriate driving licence? ☐ yes ☐ no

E. 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 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 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.

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* Applies to Polish citizens only.