więcej / niż standard

Insurance Claim Form

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

In order to ensure that your claim is considered quickly and efficiently, please fill in this form in carefully and send it directly to the address of the company providing the loss settlement service and acting on behalf of AXA Ubezpieczenia TUiR S.A. (see below).

Please enclose the following with the form:

1. original bills for the costs incurred
2. a photocopy of your ID document (ID card or passport)
3. medical records containing the medical diagnosis, and other documents stating the cause and extent of medical assistance

Contact address:

Inter Partner Assistance Polska S.A.
ul. Prosta 68
00-838 Warsaw
phone +48 22 575 90 80

A. GENERAL INFORMATION

1. **First and last name of the person filling the form** (or legal guardian)

2. Contact phone no. ☐☐☐☐☐☐☐☐☐

3. **First and last name of the insurance holder**

4. Address

Town/City _____ Postcode ☐☐-☐☐☐ Street _____ House/Apt. No. ☐☐☐/☐☐☐

Contact phone no. ☐☐☐☐☐☐☐☐☐

5. Correspondence address

Town/City _____ Postcode ☐☐-☐☐☐ Street _____ House/Apt. No. ☐☐☐/☐☐☐

6. E-Mail Address

Do you wish to receive letters correspondence and notifications via e-mail? ☐ Yes ☐ No

7. PESEL no.* ☐☐☐☐☐☐☐☐☐☐☐

8. Bank account number of the Beneficiary, to whom compensation will be paid ☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

9. Name of the bank

10. First and last name of the account holder

11. How the payment is to be made ☐ postal order (*please specify the residence address, if different from the address above*)

Town/City _____ Postcode ☐☐-☐☐☐ Street _____ House/Apt. No. ☐☐☐/☐☐☐

12. Policy/booking No.

13. Date and place of policy purchase (does not apply to individual policies)

14. Name of trip organiser – travel agency (concerns group policies as part of agreements with tourist trip organisers)

B. INFORMATION CONCERNING THE TRIP

1. Country where the incident occurred

2. Beginning of travel
   date of departure D D M M Y Y Y Y time H H M M

3. End of travel
   date of departure D D M M Y Y Y Y time H H M M

* Applies to Polish citizens only.

C. LOSS INFORMATION

1. Date of illness/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. notified of the incident? ☐ Yes ☐ No
If not, why not?

D. DESCRIPTION OF THE INCIDENT

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

2. Since when has the Insured suffered from these ailments, and when was medical advice first given in this regard?

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

4. Were there any witnesses to the accident? ☐ Yes ☐ No
Please provide the personal details of people involved in the accident or its witnesses:

5. Was the Insured under the influence of alcohol at the time of the incident? ☐ Yes ☐ No

6. Was the Insured under the influence of drugs or other intoxicants at the time of the incident? ☐ Yes ☐ No

E. INFORMATION ON THE COSTS INCURRED

Please provide a list of all costs incurred.

The bases for the reimbursement of expenses are the original receipts for the costs incurred
(if necessary, please continue on a separate sheet).

Description of the bill *(e.g. medication, medical advice, transport)*	**Date of bill**	**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 has been paid, please indicate who paid the bill:*

F. DATA CONCERNING OTHER INSURERS

1. Does the Insurance Holder have any other policy covering the costs of treatment/life-saving? ☐ Yes ☐ No
If so, please indicate the name and address of the insurance company and the policy number:

2. Does the Insured have a bank card that offers medical insurance? ☐ Yes ☐ No
If so, please indicate the name and address of the bank and the card number:

G. DECLARATIONS

I give consent to the processing by AXA Ubezpieczenia TUiR S.A., with its registered office in Warsaw (00-867) at ul. Chłodna 51 ("Insurer"), of my personal data on health and addictions, provided in this form and in other documents submitted to the Insurer for the purpose of the performance of the insurance contract. The consent may be withdrawn at any time. However, its withdrawal does not affect the processing of personal data that took place before the consent was withdrawn.

☐ Yes ☐ No

D D M M Y Y Y Y

Date

Signature of the Insurance Holder or his/her proxy

I declare that prior to giving the consent to the processing of my personal data on my health I received information about the principles of the processing of personal data.

☐ Yes ☐ No

D D M M Y Y Y Y

Date

Signature of the Insurance Holder or his/her proxy

I agree for AXA Ubezpieczenia Towarzystwo Ubezpieczeń i Reasekuracji S.A. (hereinafter: the Insurance Company) and INTER PARTNER ASSISTANCE to ask the entities engaged in medical activities under the provisions on medical activity that provided health services to me, for information or medical records about the circumstances related to the assessment of insurance risk and verification of the data I have provided on my health, and to establish the right to benefit under the insurance contract and the amount of the benefit.

The scope of information about health or medical records includes:

1) the cause of hospitalisation; any diagnostic tests performed at the time and their results; other provided health benefits; treatment results and prognosis; as well as the results of the autopsy, if one was carried out;
2) the cause of outpatient treatment; any diagnostic tests performed at the time and their results; other provided health benefits; treatment results and prognosis;
3) results of any consultations provided;
4) the cause of my death.

The abovementioned information shall be provided, excluding the results of DNA tests.

I agree to share the above-mentioned data and records with the Insurance Company and INTER PARTNER ASSISTANCE.

I agree to the transfer to the Insurance Company and INTER PARTNER ASSISTANCE by the National Health Fund (NFZ) of the names and addresses of service providers that have provided healthcare services in connection with an accident or chance occurrence, which are the basis for determining the Insurance Company's liability, amount of compensation, or benefit.

I authorise the Insurance Company and INTER PARTNER ASSISTANCE to obtain information from:

– the Social Security Institution, in connection with an accident or incident that is the basis for establishing the Insurance Company's liability;
– other insurance companies with whom I am or was insured, or with whom an application was submitted to conclude or join an insurance contract, to the extent necessary to assess the insurance risk, verify the details specified by the Insured, and establish the right of the Insured to receive a benefit based on an insurance contract and the benefit amount, as well as to provide the information held by the insurance companies on the Insured's death or the information necessary to establish the right of the beneficiary under the insurance contract to receive a benefit and its amount.

The above statements, authorisations and consents shall remain in force even after my death.

D D M M Y Y Y Y

Date

Signature of the Insurance Holder or his/her proxy

If you need help with completing this form, please contact: phone +48 22 575 90 80 or e-mail axa-likwidacja.szkod@ipa.com.pl