



więcej / niż standard

insurance

Insurance Claim Form

Notification of loss under accident insurance

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. medical records of treatment (first aid provided after the incident), containing a description of bodily injuries and the medical diagnosis, as well as test results, and medical records of the continuation of treatment after the accident, with test results
2. a medical certificate of completion of treatment
3. a death certificate (if applicable)
4. a police report, if the accident occurred as a result of a traffic accident
5. testimony of witnesses
6. a photocopy of your ID document (ID card or passport)
7. a photocopy of your vehicle registration card and driver's license (if applicable)

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**

Address

 Town/City Postcode Street House/Apt. No.

Contact phone no. _____

4. Correspondence address

 Town/City Postcode Street House/Apt. No.

5. E-Mail Address

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

6. PESEL no.* _____

7. Bank account number of the Beneficiary, to whom compensation will be paid _____

8. Name of the bank

9. First and last name of the account holder

10. 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.

11. Policy/booking No.

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

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

B. INFORMATION CONCERNING THE TRIP

1. Trip duration

From DD MM YYYY to DD MM YYYY Country _____

* Applies to Polish citizens only.

C. ACCIDENT INFORMATION

1. Accident date

time

2. Location of incident

3. Circumstances of the accident

Please provide us with a detailed description of the incident and its circumstances (if the injury occurred while playing sport, please also state which sport):

4. Description of injuries

5. Address of the facility in Poland where the Insured was treated after the accident

6. Was the treatment completed? If so, please specify the date.

Yes

No

7. Was the event reported to the police/emergency services/other institutions (please specify names and addresses)

8. Was the accident reported to Inter Partner Assistance?

Yes

No

9. Was the Insurance Holder under the influence of intoxicants?

Yes

No

10. Was the Insurance Holder under the influence of alcohol?

Yes

No

11. Was the blood of the Insurance Holder tested?

Yes

No

D. PLEASE FILL OUT THE SECTION BELOW ONLY IF THE INJURY WAS CAUSED BY A TRAFFIC ACCIDENT

1. Means of transport used by the Insurance Holder (car, bus, etc.).

2. Was the Insurance Holder driving the vehicle?

Yes

No

3. If so, did the Insurance Holder have the required driver's license?

Yes

No

E. 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

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

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 the 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.

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