AXA więcej / niż standard

Insurance Claim Form

Notification of loss under accident insurance

In order to ensure that your claim is considered quickly and efficiently, please fill 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. medical certificate of completion of treatment
3. death certificate (if applicable)
4. police report, if the accident occurred as a result of a traffic accident
5. witnesses' testimony
6. photocopy of ID document (ID card or passport)
7. photocopy of 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 filing 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 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 (applies to individual policies)

14. Name of travel organiser – travel agency (concerns group policies under agreements with tour operators)

B. TRAVEL INFORMATION

1. Travel duration

from D D M M Y Y Y Y ☐☐/☐☐/☐☐☐☐ to D D M M Y Y Y Y ☐☐/☐☐/☐☐☐☐ Country _____

* Applies to Polish citizens only.

C. ACCIDENT INFORMATION

1. Accident date

D D M M Y Y Y Y time H H M M

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 agree to the processing of my personal data, including data on health and addictions, by AXA Ubezpieczenia TUiR S.A. with its registered office in Warsaw, in order to handle the claim filed.

I agree for AXA Ubezpieczenia Towarzystwo Ubezpieczeń i Reasekuracji S.A. (hereinafter: 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 information referred to above is provided without the results of genetic 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

Information on personal data processing

Please be informed that the provision of personal data is voluntary, but necessary for the implementation of the insurance contract and the consideration of the reported claim (exclusive purpose of data processing). The data controller is AXA Ubezpieczenia Towarzystwo Ubezpieczeń i Reasekuracji S.A. with its registered office in Warsaw (00-867) at ul. Chłodna 51. The data subject has the right to access and correct his/her personal data, as well as to file a written reasonable request for cessation of the data processing due to their particular situation, and to object to the data being processed.

D D M M Y Y Y Y

Date

Signature of the person filing the claim (if other than the Insured)

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