insurance

więcej / niż standard

Claim form

Overseas medical and rescue expenses

In order to ensure quick and efficient processing of your claim, please complete the form in detail and send it directly by letter to the address of the loss adjustment company acting on behalf of AXA TUiR S.A. as stated below.

Mailing address:

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

Please submit the form with the following:

For claims related to medical and/or rescue expenses due to sudden illness:

1. insurance policy or confirmation of insurance surrender from the tour operator
2. original bills for the expenses incurred
3. photocopy of the identity card (national ID card or passport)
4. medical documentation including doctor's diagnosis and other documents stating the reason for and the extent of medical assistance
5. death certificate (if applicable)

For claims related to medical and/or rescue expenses due to accident:

1. insurance policy or confirmation of insurance surrender from the tour operator
2. original bills for the expenses incurred
3. photocopy of the identity card (national ID card or passport)
4. photocopy of the vehicle registration document and the driving licence (if applicable)
5. medical documentation including doctor's diagnosis and other documents stating the reason for and the extent of medical assistance
6. description of the circumstances surrounding the accident/witnesses' testimonies
7. police accident scene report (for transport accidents)
8. death certificate (if applicable)

A. GENERAL DETAILS

1. **Full name of the claimant**
   (or legal guardian)

2. Contact telephone

   ⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋

3. **Full name of the insured**

Address

⌊_⌋⌊_⌋-⌊_⌋⌊_⌋⌊_⌋ _____ _____
postal code locality street

⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋
telephone

4. Mailing address

⌊_⌋⌊_⌋-⌊_⌋⌊_⌋⌊_⌋ _____ _____
postal code locality street

5. E-mail address

Do you agree to receive correspondence by e-mail? ☐ yes ☐ no

6. PESEL No.

7. Bank account of the beneficiary who is to receive indemnity

8. Bank name

9. Full name of the account owner

10. Insurance policy number/travel booking number

11. Date and place of the policy surrender (applies to individual policies)

12. Name of the travel agency – travel operator (applies to group policies under agreements with tour operators)

B. TRAVEL DETAILS

1. Departure date D D M M Y Y Y Y Time H H M M

2. Return date D D M M Y Y Y Y Time H H M M

C. LOSS DETAILS

1. Date of the 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 event? ☐ yes ☐ no
   If no, why?

D. PLEASE FILL IN THE SECTION BELOW ONLY IF THE CLAIM IS RELATED TO SUDDEN ILLNESS

1. Detailed description of illness and diagnosis
   (please provide a detailed description of the condition; in the case of death, please enclose the death certificate):

2. Since when had the insured suffered from those conditions and when did they first receive relevant medical advice?

3. Did the illness occur in the past? ☐ yes ☐ no
   If yes, please state the start date for the conditions: D D M M Y Y Y Y

4. Please state the full name of the insured's doctor and the address of medical facilities where they were treated in Poland

E. PLEASE FILL IN THE SECTION BELOW ONLY IF THE CLAIM IS RELATED TO AN ACCIDENT

1. What was the cause of the accident?
Please give detailed circumstances surrounding the accident:

2. Were there other persons involved in the accident? ☐ yes ☐ no

3. Were there any witnesses to the accident? ☐ yes ☐ no
If you have answered yes to question 2 and/or 3, please give personal details of persons involved in the accident or the witnesses to the accident:

4. Was a police report prepared on the scene? ☐ yes ☐ no
If yes, please state the address of the relevant unit:

5. Was the injured the accident perpetrator? ☐ yes ☐ no
If no, please state the perpetrator's full name, residential address, ID card number and their insurance policy (if known):

6. Please give a detailed description of the injuries

7. Was the accident caused by:

☐ taking part in competitive sport ☐ driving a motor vehicle (car, lorry) ☐ involvement in physical work

☐ practising sport (if yes – which discipline):

☐ other causes – what?

8. Who gave first aid to the injured (name of the doctor, address of the medical facilities)?

F. DETAILS OF COSTS INCURRED

Please list all the costs incurred.

For the expenses to be reimbursed, original bills must be submitted
(continue on a separate sheet if necessary).

Description of the bill *(such as medicines, medical advice, transport)*	**Bill issue date**	**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 state by whom:*

G. DETAILS OF ANOTHER INSURER

1. Does the injured have another insurance policy covering medical/rescue expenses? ☐ yes ☐ no
If yes, please state the company name and address and the policy number:

2. Does the injured have a bank card providing coverage for medical expenses? ☐ yes ☐ no
If yes, please state the name and address of the bank and the card number:

H. STATEMENTS

I give my authority to have my personal data, including my health data, processed for the purposes of this application.

I give my authorisation for the Insurance Company to inquire about any medical information as regards my health, genetic test results excepted, from any doctor whose treatment or advice I have used and from any medical facilities and health care establishments whose health services I have used. At the same time I give my authority to the Insurance Company to obtain any and all information about my health from doctors, medical facilities and health care establishments.

I give my authorisation to the Insurance Company to inquire about the accident or the event being the basis for establishing the Insurance Company's liability from courts, prosecutor's offices, the police and other authorities and institutions.

_____	D D M M Y Y Y Y
Signature of the insured or attorney	Date

I hereby confirm that all information stated above is true and that I am aware that giving false testimony or statements may give rise to criminal liability and refusal to pay the indemnity.

_____	D D M M Y Y Y Y
Signature of the claimant	Date

Pursuant to the Act of 29 August 1997 on the Protection of Personal Data (J. of Laws No. 133, item 883 as amended), we inform you that submission of data is voluntary. Your personal data will be stored and processed by AXA TUiR S.A. and Inter Partner Assistance Polska S.A. with its registered office in Warsaw: 00-867 Warsaw, ul. Chłodna 51 for the purposes of and to the extent required by implementation of the insurance agreement. You have the right to access and rectify your personal data.

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