insurance

więcej / niż standard

Claim form

Accident insurance

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 and confirmation of travel booking at the tour operator
2. medical documentation of treatment (first aid after the event including a description of injuries, doctor's diagnosis and test results as well as medical documentation from post-accident continuation of treatment and test results)
3. doctor's certificate stating the end of treatment
4. death certificate (if applicable)
5. police report, if the accident resulted from a transport accident
6. witnesses' testimonies
7. photocopy of the identity card (national ID card or passport)
8. photocopy of the vehicle registration document and the driving licence (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. Travel time

From D D M M Y Y Y Y To D D M M Y Y Y Y

C. ACCIDENT DETAILS

1. Date of the accident

D D M M Y Y Y Y Time H H M M

2. Place of the event

3. Circumstances surrounding the accident

What were the circumstances surrounding the accident? Please give a detailed description of the event and circumstances surrounding the accident (if the injury resulted from sport, please state the discipline)?

4. Was the insured drugged? ☐ yes ☐ no

5. Was the insured intoxicated? ☐ yes ☐ no

6. Were blood tests carried out? ☐ yes ☐ no

D. PLEASE FILL IN THE SECTION BELOW ONLY IF THE INJURY RESULTED FROM A TRANSPORT ACCIDENT

1. Type of vehicle used by the injured (car, bus, etc.)

2. Was the injured the driver? ☐ yes ☐ no

3. If yes, did the injured have the required driver's licence? ☐ yes ☐ no

E. PLEASE DO NOT FILL IN THE SECTION BELOW, IF YOU HAVE ANSWERED THESE QUESTIONS IN THE MEDICAL EXPENSES CLAIM FORM OF AXA TUiR S.A. PLEASE GIVE THE LOSS REFERENCE NUMBER ONLY

loss reference number

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

2. Were there any witnesses to the accident? ☐ yes ☐ no

If you have answered yes to question E.1 and/or E.2, please give personal details and addresses of persons involved in the accident or the accident witnesses:

3. Was a police report prepared on the scene? ☐ yes ☐ no

If yes, please state the address of the relevant unit:

4. Please give a detailed description of the injuries

5. Was the accident caused by:

☐ taking part in competitive sport ☐ suicide ☐ involvement in physical work

☐ practising sport (if yes – which discipline)

☐ other cause, what?

6. Was the insured hospitalized because of the illness/treatment? ☐ yes ☐ no

From D D M M Y Y Y Y To D D M M Y Y Y Y

If yes, please enclose the hospital discharge summary.

7. Was the injured treated as an outpatient? ☐ yes ☐ no

If yes, please state the address of the surgery and the full name of the attending doctor:

Date of the first medical advice D D M M Y Y Y Y

8. If the injured was also treated by another doctor or at other medical facilities, please state the full name of the doctor and the address of the surgery or facility:

F. 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.

Signature of the insured or attorney	D D M M Y Y Y Y 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.

Signature of the claimant	D D M M Y Y Y Y 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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