TRAVEL INSURANCE

Application for indemnity (regarding the deterioration of health status or death of a person)

VIENNA INSURANCE GROUP

Applicant

Name, Surname: _____ Personal No: _____

Address: _____ Postal code: _____

Phone: _____ e-mail: _____

Policy No: _____ Travel start and end date: _____

Insured's representative (If claim is submitted in light of insured):

Name, Surname/Appellation: _____ Personal No/Reg.No.: _____

Address: _____ Postal code: _____

Phone: _____ e-mail: _____

Information on the Accident

Date: _____ Time: _____ Place (address): _____

Information about circumstances of this accident

Doctor's opinion (diagnosis): _____

Type of the accident:

☐ Accident:

☐ household injury ☐ injury in the event of a road traffic accident ☐ sports injury ☐ injury at work ☐ other _____

☐ Emergency dental services ☐ Acute serious illness ☐ Death ☐ Other _____

Description of the accident (Detailed description of the course of events in chronological order. If necessary, attach separate pages.):

Witnesses of the accident: 1. _____

2. _____

(if available, specify the name, surname, personal identity number, address and telephone number)

Applicant

Name, Surname: _____

Signature: _____

Date: _____

Additional Information

Did the insured used alcohol, narcotic or psychotropic substances or medicinal products not prescribed by a doctor on the day of the accident?	No ☐ Yes ☐	(Specify directly)
Was the filed accident caused by a road traffic accident?	No ☐ Yes ☐	(Specify the brand and reg. plate No of the vehicle that caused the road traffic accident and the authority that performed the investigation of the road traffic accident circumstances)
Was there any other insurance contract concluded in relation to the claimed accident that was valid at the moment of the accident?	No ☐ Yes ☐	(Specify the insurance company)
Can the persons accountable for the accident be specified?	No ☐ Yes ☐	(If there are several, specify all)
Did the guilty party voluntarily agree to compensate for the damages?	No ☐ Yes ☐	(Specify in what way and amount)

Insurance indemnity transfer to account

☐ Paying for the services provided by a service provider

☐ Transfer:

☐ Insured ☐ Authorized person (Authorization must be presented) ☐ Other person

Receiver of an indemnity:

Name, Surname/Appellation: Personal No/Reg.No.:

Address: Postal code:

Name of the bank:

Account number: Currency:

After the decision is made, the partially paid and unpaid payment documents:

☐ Should not be sent to me

☐ Should be sent to me by post to the address of the Insured specified in the claim

Information on the Documents Attached to the Claim

1. _____

2. _____

3. _____

4. _____

Payment Document	Amount	Total amount

By signing this application:

1 I acknowledge that I am aware that in relation to this insurance claim, BTA will record telephone and oral conversations, and record other information related to the potential insured event by means audio and video recording and storage devices with the right to use these records as evidence in court in a dispute regarding insurance indemnity payment;

2 I hereby authorize BTA (common reg.No. 40103840140) to obtain from other legal subjects (including medical staff, medical institutions) information, required for assessment of the potential insured event, about the health condition of the insured person and the medical aid received by the insured person;

3 I confirm that the information provided is true, complete and accurate. It has been explained to me that in the case of being provided with untruthful or deceptive information, BTA is entitled to reduce the size of insurance indemnity or reject in its payment, as well as that it entails criminal liability under Section 177 (fraud) or Section 178 (insurance fraud) of the Criminal Law. Should BTA reduce the size of insurance indemnity or reject in its payment based on the aforementioned reasons, I pledge to compensate all damages caused thereby;

4 I am aware that insurance indemnity payment is made only after all the necessary documents confirming insured event occurrence and the losses caused thereby, are submitted to BTA;

5 I agree that the fee for partially paid and unpaid delivery of documents by registered mail will be deducted from the insurance indemnity, when I have specified this kind of receipt of payment documents in the insurance claim application;

6 I agree that in cases, when the insurance indemnity disbursed by BTA covers a part of the losses caused as a result of the insured event, BTA is entitled to exercise its rights to recourse claim against the person at guilt for losses irrespective whether I, the Insured, do or do not exercise my rights to bring claim against this person.

7 Should BTA make a decision to reject in insurance indemnity payment, I will inform the Policyholder about the BTA's decision.

8 I confirm that I am entitled to sign this application.

BTA informs that execution of the concluded insurance contract entails rights for BTA under the Personal Data Protection Law: in compliance with this Law, to process, incl. to obtain from registers and databases the personal data of the Insured and the Beneficiary, to include personal identification codes for the provision of insurance services and namely: for adjustment of the reported insurance risk occurrence, for decision making on regarding the insured risk occurrence an insured event, for insurance indemnity size estimation and insurance indemnity payment.

The submitting of this application will entitle BTA to process the sensitive data of the Insured, as insurance indemnity adjustment is not feasible without processing the sensitive data of the Insured.

☐ Hereby I grant my consent to BTA to process my personal data, incl. identification codes for conducting statistical, market and public opinion studies, analysis and reporting, as well as conducting customer surveys and for risk management purposes.

Applicant

Name, Surname:

Signature:

Date:

Is filled in by BTA representative!

Received on:

Name, surname of the receiver:

Signature: