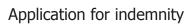
PERSONAL ACCIDENTS INSURANCE





| Applicant | | |
|--|---|--|
| Name, Surname: | Personal No: | |
| Address: | Postal code: | |
| Phone: | e-mail: | |
| Policy No: | | |
| Insured (injured person) | | |
| Name, Surname: | Personal No: | |
| Address: | Postal code: | |
| Phone: | e-mail: | |
| Insurance agreement information | | |
| Personal Accident insurance agreement with BTA was concluded by: | | |
| bank (name of the bank): other person | | |
| employer (name of the employer): | | |
| Informācija par negadījumu | | |
| Date: Time: Place (addre | ss): | |
| Medical institution providing medical aid: | | |
| Information about circumstances of this accident | | |
| This is a notification of: injury disability caused by an acciden | t death caused by an accident critical illness | |
| The accident has occurred: | affic accident during sports activities otherwise | |
| Description of the accident (Detailed accident description in chronological order. If necessary, attach a separate sheet): | | |
| | | |

| Applicant |
|----------------|
| Name, Surname: |
| Signature: |
| Date: |

Additional information Had the Insured, within twenty-four hours prior to the accident, (please, specify) No Yes consumed alcohol, used narcotic or psychotropic substances, or drugs not prescribed by the doctor? (please, specify) Has the accident been reported to the police or other law No Yes enforcement institution? Insurance indemnity transfer to account Beneficiary Heir Receiver of an indemnity: Name, Surname/Appellation: Personal No/Reg.No.: Address: Postal code: Name of the bank: Account number: Currency: Partially paid and unpaid documents after decision: Don't want to receive Want to receive by post to above mentioned Insured's address Information about the documents attached to the application (e.g., a police statement, etc. documents): Payment Document Amount Total amount By signing this insurance claim application hereunder, I confirm that: 1) the information provided by me is true, complete and accurate; 2) I hereby provide my consent to BTA to receive any information at any medical institution regarding the health condition of the Insured and medical aid received by the Insured, should such information be required by BTA for considering the circumstances of the accident and to determine the amount of insurance indemnity. Also, at the first request of BTA, the Insured shall grant its consent to the respective medical institution to release any information referred to above to BTA thus relieving the medical institution and the medic working for it from the non-disclosure obligation. 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 Policyholder, 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.

Is filled in by BTA representative!

Name, surname of the receiver:

Received on:

Signature:

Applicant
Name, Surname:

Signature:

Date: