

PERSONAL ACCIDENTS INSURANCE

Application for indemnity for members of LSUMF



Applicant

Insured:

Name, Surname: _____ Personal No: _____

Address: _____ Postal code: _____

Phone: _____ e-mail: _____

Ship's name: _____ Policy/card number: _____

Employer (Shipping company) name: _____

Position on board: _____ Norakstīšanas datums: _____

Deaccession reason: _____

Apdrošinātā pārstāvis (Ja pieteikumu iesniedzat apdrošinātā vārdā):

Name, Surname: _____ Personal No: _____

Address: _____ Postal code: _____

Phone: _____ e-mail: _____

Information about the accident

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

Information about circumstances of this accident

Type of event:

- illness social trauma trauma for road traffic accident sport's trauma work trauma death
 other _____

Sick-leave certificate: No Yes

From date: _____ Till date: _____

Issued by: _____

Description of the accident (Detailed accident description in chronological order. If necessary, attach a separate sheet):

Applicant

Name, Surname: _____

Signature: _____

Date: _____

Papildu informācija

Was at the date of accident insured under the influence of alcohol, other narcotic substances or used medicine not prescribed by doctor?	No <input type="checkbox"/> Yes <input type="checkbox"/>	(state, what exactly)
Was this accident caused with regards to road traffic accident?	No <input type="checkbox"/> Yes <input type="checkbox"/>	(state vehicle made, registration plate number, institution which investigated)
Are other insurance contracts signed in relation to this accident?	No <input type="checkbox"/> Yes <input type="checkbox"/>	(state the insurance company)

Witnesses of the Accident: 1
2
(if it is known, mention name, surname, personal code, address, phone number)

Insurance indemnity transfer to account

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: _____

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 attached documents

	Payment Document	Amount	Total amount
<u>1</u>			
<u>2</u>			
<u>3</u>			
<u>4</u>			

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 to obtain from other legal subjects (including medical staff, medical institutions, Health Payments Centre) 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.

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 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 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.

Applicant

Name, Surname: _____

Signature: _____

Date: _____