TRAVEL INSURANCE INDEMNITY

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



Filled out by a BTA representative!				
Received on:	Reference No of indemnity claim:			
Place where received:				
Name, surname of the receiver:				
Signature:				
Applicant:				
Name, Surname: John Doe	Personal No: 1805642222			
Address: Wilhelmstrasse 49/15 G Berlin, Germany	Postal code: D-10117			
Phone, fax: +49 12346 789	e-mail: john.doe@gmail.com			
Policy series: CN - 15 number: 80234050	I agree, to receive related information from BTA by email: No \(\subseteq \) Yes \(\subseteq \)			
Insured's representative (If claim is submitted in light of insured)				
Name, Surname: Julia Doe	Personal No: 190699 11111			
Address: Wilhelmstrasse 49/15 G Berlin, Germany	Postal code: D-10117			
Phone, fax: +49 12346 789	e-mail: julia.doe@gmail.com			
Information on the Accident:				
	Riga, Skanstes street 16			
Information about circumstances of this accident:	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			
Doctor's opinion (diagnosis): arm fracture				
Type of the accident: X Accident				
X household 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.) I was walking down the stairs, slipped on right side. In result right arm hurt. Doctor told it's fractured.				
Witnesses of the accident: 1				
2. (if available, specify the name, surna	me, personal identity number, address and telephone number)			
Applicant:				
Name, surname: John Doe				
Signature:				
Date: 10.01.2010 1/2				

Additional Information:				
	1			
Did the insured used alcohol, narcotic or psychotropic substances or medicinal products not prescribed by a doctor on the day of the accident?	No X Yes	(Specify directly)		
Was the filed accident caused by a road traffic accident?	No X Yes	(Specify the brand and registration plate number 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 X Yes	(Specify the insurance company)		
Can the persons accountable for the accident be specified?	No X Yes	(If there are several, specify all)		
Did the guilty party voluntarily agree to compensate for the damages?	No X Yes	(Specify in what way and amount)		
Insurance indemnity transfer to account:				
Paying for the services provided by a service provider Transfer: X Insured	must be presented)	Other person		>
			/	100000 11111
Name, Surname: Julia Doe		Person	ial No/Reg. No:	190699 11111
Address: Wilhelmstrasse 49/15 G Berlin, Germany		Postal	code: D-1011	.7
Name of the bank: AS SEB				
			1.) // /EUD	
Account number: L / V / X / X / U / N / L / A / X / X / X	_/X / X / X / X / X	X X X X X Curren	cy: LVL/EUR	
After the decision is made, the partially paid and unpaid Should not be sent to me Should be sent to me by post to the address of the Insured spe as a standard letter free of charge		nts:		
as a registered letter, paying to BTA in accordance with	h the effective priceli	st		
Information on the Documents Attached to the Claim:				
 copy from policy 		Payment Document	Amount	Total amount
2. copy from passport		check Nr.2334	1	2 LVL
3. doctor's extract		check Nr.2335	1	15 LVL
4.				
By signing this application:				
	DTA will record tolo	shape and verbal conversations, and et	har information	ralated to the notantial
 confirm that I am informed that in relation to this insurance claim insurable event, using audio and video recording and storage device 				
disbursement of the insurance indemnity; 2. authorise BTA (Unified registration number 40003159840) to receiv person's health condition and received medical help, in order to prop 3. confirm that the provided information is complete and accurate. C to reduce or refuse to pay out the insurance indemnity and criminal li	ve from other sources perly investigate the c Confirm that I am awa iability referred to in S	(including doctors, hospitals, medical ins ircumstances of the potential insurable or re that in the event of providing false or section 177 (Fraud) or Section 178 (Insu	stitutions) inform event; misleading info rance Fraud) ma	nation about the insured rmation, BTA is entitled by set in. If BTA reduces
or refuses to pay out the insurance indemnity due to the aforementic 4. confirm that I am aware that the insurance indemnity is paid out or amount of losses caused thereby to BTA; 5. confirm that for the execution of the insurance contract I authorise receive and process personal data provided in the claim, including ser	only after submitting a se BTA, as the mana nsitive personal data	all required documents confirming the or ger of the system, recipient of personal	ccurrence of an i	insurable event and the tor of personal data, to
Data Protection Law and other regulatory enactments of the Republic 6. agree that the payment for sending the partially paid or unpaid do type of receipt of payment documents in the claim; 7. confirm that I am entitled to sign this Claim.		d mail is deducted from the insurance in	demnity in the e	event of specifying such
Applicant:				
Name, surname: John Doe				
Signature:				