

TRAVEL INSURANCE INDEMNITY

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



Filled out by a BTA representative!

Received on: _____
Place where received: _____
Name, surname of the receiver: _____
Signature: _____

Reference No of indemnity claim: _____

Applicant:

Name, Surname: _____ Personal No: _____
Address: _____ Postal code: _____
Phone, fax: _____ e-mail: _____
Policy series: _____ number: _____ I agree, to receive related information from BTA by email: No Yes

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

Name, Surname: _____ Personal No: _____
Address: _____ Postal code: _____
Phone, fax: _____ e-mail: _____

Information on the Accident:

Date: _____ Time: _____ Place: _____

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: _____

