

INSURANCE CLAIM NOTIFICATION – NECESSARY AND URGENT CARE HEALTH INSURANCE (TRAVEL INSURANCE OR FOREIGNERS INSURANCE)

Insurance policy No.: [] Type of insurance: [] Start of insurance coverage: [] End of insurance coverage: []

If you wish to exercise your right to insurance benefits, please, fill in this form and send it to the address: Slavia pojišťovna a.s., Revoluční 1, 110 00 Praha 1

Insured person: (to be filled in by the insured person or his/her statutory representative; please write legibly – type or use block letters)

Surname, name: []
Address in the Czech Republic: []
Phone No.: [] Identity card No.: []
Residence permit No.: []

Description of the event: (please tick below as applicable)

Necessary and urgent care Out-patient medication Dental care Other medical care

Date and time when the event occurred: []

Place where the event occurred: []

Identify in detail all circumstances and causes of your disease or injury:

When and how the disease manifested itself, or, if applicable, what part of your body was injured?

What was the diagnosis, if known to you:

Have you experienced symptoms of the disease for which you sought medical attention or have you been treated for that disease ever before your insurance coverage started?

Have you used or do you still use any medication for that disease? If so, please state what kind of medication is that:

Name and address of the medical facility (or of the physician) that provided treatment:

Identify the physician in the Czech Republic who is best informed about your health condition (name and address):

Is there anyone to be blamed for your disease/injury? Yes No

If YES, provide the name and address of that person:

Was the case investigated? Yes No

Provide the name, address and file. No., or, if applicable, attach the report developed by the investigator or by the police:

Provide a list of documents supporting your insurance claim and their amount:

(medical reports, bookkeeping vouchers, receipts and other documents)

Total amount for medical care in CZK:

Pursuant to S. 31 of the Civil Code and Ss. 50 and 51 of the Criminal Code (S. 33 of the Administrative Procedure Code), I hereby authorise any staff member of Slavia pojišťovna a.s., to check the case file of the Police of the Czech Republic, make excerpts therefrom, make copies thereof at his/her own expense, file motions to investigative, prosecuting and adjudicating bodies to find additional evidence; file motions, make requests and demand remedial measures along with the injured party within the meaning of S. 65 of the Criminal Code (S. 38 of the Administrative Procedure Code) for the purposes of the above insurance claim settlement. I also authorise all the enquired physicians, medical facilities and health insurers to provide to Slavia pojišťovna a.s. all sensitive information about my health condition.

Declaration:

I declare that I have answered all questions truthfully and completely and I am aware of the consequences of providing false information and facts in terms of the obligation of the insurer to pay out insurance benefits.

Please send the insurance benefits:

to the bank account in the Czech Republic:

Bank name:

Account No.: Bank code:

with a money order to the address in the Czech Republic

Name and surname:

Street and house No.: Post code: Municipality:

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Signature of the insured person, or the name, surname and signature of his/her statutory representative