Loss report form under travel insurances offered by UNIQA Towarzystwo Ubezpieczeń S.A.

Form

In order to process your claim quickly and efficiently, please complete the form below carefully, attach the required documents (according to the type of loss) and send by correspondence or electronic means to the following address of the company providing the loss adjustment service and operating on behalf of UNIQA Towarzystwo Ubezpieczeń S.A.

Required documents:

1) medical records with diagnosis and date of assistance
2) bills for incurred costs
3) medical records of the continuation of post-accident treatment along with test results
4) medical certificate on treatment completion (accident insurance)
5) death certificate, death record and statistical certificate for the death record or other document determining the cause of death
6) report from the scene from the police, fire brigade or other services whose intervention was required
7) witness testimony
8) documents confirming the claim against the Insured Party (liability insurance)
9) medical records in case of personal injury (liability insurance)
10) bills for the repair or purchase of damaged/destroyed item (liability insurance)
11) confirmation of destruction, loss or theft of luggage
12) confirmation from the carrier of the delayed luggage, flight
13) confirmation of the purchase of sports equipment belonging to the Insured Party, which has been stolen or damaged
14) travel contract (e.g. package travel contract, confirmation of accommodation booking, ticket purchase, yacht rental)
15) confirmation of payment for the travel contract, ticket purchase (trip cancellation insurance)
16) written certificate from the travel agency or other provider of travel services, confirming the Insured Party's resignation and containing information on the amount reimbursed to the Insured Party by the travel agency or other provider of travel services (trip cancellation insurance)
17) written confirmation from the carrier that the ticket has been cancelled and the costs have been deducted (trip cancellation insurance)
18) bills and proofs of payment for return transport in the case of a sudden return and interruption of trip
19) documentation confirming the need to cancel the trip (medical records, certificate issued by the police or the appropriate authority)
20) other documents related to the occurring event aimed at determining the Insurer's liability.

Correspondence address:

Inter Partner Assistance Poland S.A.
Giełdowa Street no. 1
01-211 Warsaw
phone number: +48 22 575 90 80
e-mail: likwidacja@ipa.com.pl

A. GENERAL INFORMATION

The claim relates to the following insurance:

- ☐ Medical treatment costs and assistance
- ☐ Accident insurance
- ☐ Luggage insurance
- ☐ Luggage/flight delay insurance
- ☐ Liability insurance
- ☐ Trip cancellation or interruption insurance
- ☐ Insurance of cash withdrawn from the ATM
- ☐ Insurance of movable property left at home while travelling abroad
- ☐ Sports equipment insurance
- ☐ Insurance of medical expenses/rehabilitation expenses/hospital stay in Poland
- ☐ Insurance on reimbursement for unused carnet, ski/snowboard equipment rental

1. Name and surname of the person reporting the loss

2. Phone number

3. Email address

4. Name and surname of the insured person

5. Date of birth D D M M Y Y Y Y

6. Residence address

Postal code ____-____ Town _____ Street _____ Street address/suite number ____/____

Country of permanent residence _____

7. Phone number

8. Email address

UNIQA Towarzystwo Ubezpieczeń S.A., Chlodna Street no. 51, 00-867 Warsaw, phone no.: 22 599 95 22, www.uniqa.pl
Registration authority: District Court for the Capital City of Warsaw, 13th Commercial Division of the National Court Register
KRS no.: 271543; NIP no.: 107-00-06-155; Share capital: PLN 141,730,747 – paid-up in full

9. Correspondence address

Town _____ Postal code _____-_____ Street _____ Street address/suite number _____/_____

Do you agree to receive correspondence also electronically? ☐ Yes ☐ No

B. INFORMATION ON THE INSURANCE

1. Policy number

2. Insurance period from D D M M Y Y Y Y to D D M M Y Y Y Y

3. Date of purchasing the policy (applies to individual policies) D D M M Y Y Y Y

4. Name of the Travel Agency – the trip organizer (applies to group policies under contracts concluded with travel organizers)

5. Does the Insured Party have any other insurance covering the occurrence of the event? ☐ Yes ☐ No
If yes, please specify:

Name of the Insurer/Bank issuing the card

Policy number

Insurance period from D D M M Y Y Y Y to D D M M Y Y Y Y

Bank card number

C. INFORMATION ON THE TRIP

1. Country of destination

2. Start of the trip date of departure D D M M Y Y Y Y time H H M M

3. End of the trip date of departure D D M M Y Y Y Y time H H M M

4. Trip/flight booking number

D. INFORMATION ON THE LOSS

1. Has the event been reported to the Assistance Emergency Center?

☐ Yes – *please provide the case number:*

☐ No – *please state the reason:*

2. Date and time of the event D D M M Y Y Y Y H H M M

3. Country and scene

4. Type of event:

☐ Sudden illness *(please state from when (date) and what symptoms, what diagnosis, scope of assistance provided):*

☐ Accident *(please state the circumstances and reasons for the event, scene, scope of assistance provided)*:

☐ Traffic accident *(please state the circumstances and reasons for the event, scene, scope of assistance provided)*:

☐ Other

5. Since when the Insured Party suffered from these aliments and when the first medical advice in this regard took place?

6. Description of event

7. Has the loss occurred as a result of the consumption of: alcohol/abusive substances/medicines? ☐ Yes ☐ No

8. Has the event been reported to the relevant services (police, guard, emergency services)? ☐ Yes ☐ No

E. INFORMATION ON THE COSTS INCURRED

Please provide the list of all costs incurred.
The basis for reimbursement of expenses is the submission of original bills for the costs incurred
(if necessary, please continue on a separate sheet).

Description of the bill *(e.g. medicines, medical advice, transport)*	**Bill issue date**	**Amount and currency**	**Paid***
1)	D D M M Y Y Y Y		☐ Yes ☐ No
2)	D D M M Y Y Y Y		☐ Yes ☐ No
3)	D D M M Y Y Y Y		☐ Yes ☐ No
4)	D D M M Y Y Y Y		☐ Yes ☐ No
5)	D D M M Y Y Y Y		☐ Yes ☐ No

** If the bill has been paid, please specify who paid the bill:*

F. TRANSFER DETAILS

Payment order

Account number

Recipient's bank

Recipient's name and surname

Recipient's address

Postal code | Town | Street | Street address/suite number

G. DECLARATIONS

I consent to the processing by UNIQA Towarzystwo Ubezpieczeń S.A., with its registered office in Warsaw (00-867) at Chlodna Street no. 51 (hereinafter referred to as: The Insurance Company), of my personal data concerning health and addictions, indicated in this application and in other documents submitted to the Insurance Company for the purpose of performance of the concluded insurance contract. You can withdraw your consent at any time. However, its withdrawal does not affect the correctness of data processing that took place prior to consent withdrawal.

☐ Yes ☐ No

D D M M Y Y Y Y
Date

Signature of the Insured Party or representative

I declare that before agreeing to the processing of my personal data on the state of health, I received information on the rules governing the processing of personal data.

☐ Yes ☐ No

D D M M Y Y Y Y
Date

Signature of the Insured Party or representative

I consent to requesting by UNIQA Towarzystwo Ubezpieczeń S.A. (hereinafter referred to as: The Insurance Company) and INTER PARTNER ASSISTANCE Polska S.A. the entities conducting medical activities, within the meaning of the provisions on medical activities, that provided me with healthcare services, for information or medical records concerning the circumstances related to the assessment of the insurance risk and verification of data on the state of health provided by me, establishment of the right to the benefit under the concluded insurance contract and the amount of the benefit.

The scope of information on the state of health or medical records covers:

1) the reasons for hospitalization, diagnostic tests and their results, other healthcare services provided, treatment results and prognosis, as well as autopsy report, if performed;
2) the reasons for outpatient treatment, diagnostic tests and their results, other health services provided, treatment results and prognosis;
3) results of consultations held;
4) causes of my death.

The aforementioned information is provided excluding the results of genetic tests.

I agree to share the aforementioned data and documentation with the Insurance Company and INTER PARTNER ASSISTANCE Polska S.A.

I agree for the National Health Fund providing the Insurance Company and INTER PARTNER ASSISTANCE Polska S.A. with the data on the names and addresses of healthcare providers who provided me with healthcare services in connection with the accident or fortuitous event constituting the basis for establishment of the Insurance Company's liability and the amount of compensation or benefit.

I authorize the Insurance Company and INTER PARTNER ASSISTANCE Polska S.A. to obtain information from:

– The Social Insurance Institution, in connection with the accident or event constituting the basis for establishment of the Insurance Company's liability;
– other insurance institutions, in which I am or was insured or in which the application was submitted to conclude or access the insurance contract, to the extent necessary to assess the insurance risk and verify the data provided by the Insured Party, as well as to establish the Insured Party's right to the benefit under the insurance contract and the amount of the benefit, as well as to provide information possessed by these insurance institutions about the cause of the Insured Party's death or information necessary to establish the right of the insured party under the insurance contract to the benefit and its amount.

The aforementioned declarations, authorizations and consents remain in force also after my death.

D D M M Y Y Y Y

Date

Signature of the Insured Party or representative

If you need help completing the forms, please contact us at: +48 22 575 90 80 or: likwidacja@ipa.com.pl