Poisťovňa

INSURANCE CLAIM FORM
Health Insurance for Foreigners in the Slovak Republic

Insurance policy number:

Data on insured person

Name and Surname:	Date of birth: *if is assigned Birth number:
Name and surname of the legal representative of the insured person:	Policyholder:
Place of residence (city, street and number, postal code)/temporary stay in the Slovak Republic:	E-mail: Phone number:*

Information about insurance event * The SMS will also send you a notification of the event

Injury	Date, time and place of injury:
	Circumstances of injury:
	Type of injury:
	When did you get medical help for the first time? (date, time, healthcare facility)
	Have you been at the time of the accident under the influence of alcohol, drugs or narcotics? □ Yes □ no
	Has your injury been investigated by the police? □ Yes □ no If yes, please attach report
Disease	Name of disease/diagnosis:
	When the first symptoms of the disease began to appear:
	When did you get medical help for the first time? (date, time, healthcare facility)
	Have you been previously treated for this disease? □ Yes □ no

Documents on provided healthcare

I am aware of the fact that only the insured who will attach the following documents (depending on the type of health-care provided) to this report is entitled to reimbursement of health care costs:

☐ medical report of the disease, or injury with the diagnosis confirmed by the healthcare provider

☐ **original** cash payment document for medical costs issued by the healthcare provider, which must include: name of the insured, date of birth, stamp with the date of issue and signature of the healthcare provider, including codes and breakdown of services according to the Catalogue of Healthcare Services

☐ copies of drug prescriptions if are issued in connection with the claim

☐ document from the cash register on cash payment for drugs, indicating type of drugs number of packages and price

☐ **original** document proving payment for transport costs issued by the transport service (the document must include the name of the insured, his/her date of birth, the stamp and the signature of the transport service representative, including rates per 1 km, the route, number of kilometers and the price)

Reimbursement of paid healthcare costs

Include the amounts for reimbursement and attach original receipts:

The amount paid by the insured person (medical treatment, drugs, transport) _____ **EUR**

The way of claim payment:

Transfer to the account/**IBAN** format held with a bank in the terrirory of the Slovak Republic:

Owner of the account (name, surname / company name):

Date of birth /ID number:

Data for an account with a bank outside the Territory of the Slovak Republic:

Swift:

BIC code:

Exact name and address of the bank:

Declarations and signature

Declaration of the insured:
I declare that I answered all questions truly and completely and I am aware of possible consequences in case of withholding serious circumstances or provision of incorrect information. I declare that I became acquainted with provisions of the insurance contract on personal data protection. I agree that the company may require all the necessary medical documentation on my treatment and health condition.
I am aware that, in accord with the Law on Insurance, the insurer can process my personal information contained in this insurance claim form, including the attached documents, for the purpose of claims handling. I declare that I have been acquainted with Basic Information on Personal Data Protection for the Person Concerned located on www.union.sk
Declaration of the account owner:
Pursuant to the Law no. 122/2013 Coll. on personal data protection by signing of this insurance claim report the owner of the account (if different from the insured) gives his consent to Union poisťovňa, a.s. for processing of personal data included in this report with the aim of claim payment. The consent is given for unlimited period and it may be cancelled at any time in a written form. Cancellation shall not have retroactive effect. Personal data of the account owner will be used exclusively for purposes of claim payment and will not be provided to third persons. The processed and archived data will be in the internal information system of the insurer.

In_____, date: _____

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Signature of the insured
(in case of an under aged person the legal representative)

Date of delivery of the report: _____
Name of the employee accepting the report, contact phone no.: