

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.
Prosta Street no. 68
00-838 Warsaw
phone number: +48 22 575 90 80
e-mail: likwidacja@ipa.com.pl

A. GENERAL INFORMATION

The claim relates to the following insurance:

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 Insurance of cash withdrawn from the ATM |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

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

6. Residence address

<input type="text"/>	<input type="text"/>	<input type="text"/>
Postal code	Town	Street
		Street address/suite number

Country of permanent residence7. Phone number 8. Email address

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 DDMMYYYY to DDMMYYYY

3. Date of purchasing the policy (applies to individual policies) DDMMYYYY

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 DDMMYYYY to DDMMYYYY

Bank card number

C. INFORMATION ON THE TRIP

1. Country of destination

2. Start of the trip date of departure DDMMYYYY time HHMM

3. End of the trip date of departure DDMMYYYY time HHMM

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 DDMMYYYY HHMM

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 ailments 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)	<input type="text" value="D D M M Y Y Y Y"/>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
2)	<input type="text" value="D D M M Y Y Y Y"/>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
3)	<input type="text" value="D D M M Y Y Y Y"/>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
4)	<input type="text" value="D D M M Y Y Y Y"/>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
5)	<input type="text" value="D D M M Y Y Y Y"/>		<input type="checkbox"/> Yes	<input type="checkbox"/> 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

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

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