SLAVIA POJIŠŤOVNA

Claim No. on the policy * | Ref. No.* | Risk*

* shall be filled-in by the claims adjustment section

NOTIFICATION OF LOSS EVENT – HEALTH CARE

INSURANCE OF COSTS OF HEALTH CARE (TRAVEL INSURANCE OR INSURANCE FOR FOREIGN NATIONALS)

If you wish to exercise your right to claim indemnity based on a loss event, fill in this notification and send it to the following address:
Slavia pojišťovna a.s., Revoluční 1, 110 00 Prague 1

Insurance policy No.: | Insurance category: | Commencement of insurance: | End of insurance:

Insured person (to be filled-in by the insured person or his/her legal representative; legibly – on a typewriter/computer or in block letters)

Surname:	Name:
Address in the Czech Republic:	Postal Code:
Phone:	ID No.:
Residence permit No.:	

Event description (check the applicable event)

☐ Acute and emergency care ☐ Medicaments prescribed within outpatient care ☐ Dental care ☐ Other health care

Date and time of occurrence of the event:

Place of occurrence of the event:

Detailed account of the circumstances and causes of the illness or injury:

When and how did the illness appear; which part of your body was injured?

Specify the diagnosis if it is known to you:

Had you suffered from the illness for which you sought medical care or had it appeared before the arising of the insurance?

Have you taken any medication for your illness? If so, please specify:

Name and address of the physician / medical facility that provided the treatment:

Claim No. on the policy *	Ref. No.*	Risk*

* shall be filled-in by the claims adjustment section

Physician in the territory of the Czech Republic with the best information on your health condition (name and address):
Any suspicion of other person's fault? ☐ YES ☐ NO If you checked YES, please specify the name and address of the person:
Was there any investigation of your case? ☐ YES ☐ NO Fill in the name, address and reference number; or attach a report of the investigating body or a police report:
Fill in the list of documents evidencing the insured event and their number (Medical reports, accounting receipts, documents proving payment, etc.):
Total amount for the medical care in CZK:

Pursuant to Section 441 of the Civil Code and Sections 50 and 51 of the Code of Criminal Procedure (Section 33 of the Code of Administrative Procedure), I hereby authorise an employee of Slavia pojišťovna, a.s. to inspect the investigation file of the Police of the Czech Republic, make excerpts from it, make copies at his/her own expense, submit motions for supplementing evidence to prosecuting bodies, and submit motions, claims and appeals together with the injured party, all the above in the sense of Section 65 of the Code of Criminal Procedure (Section 38 of the Code of Administrative Procedure) for the purposes of claim adjustment. I authorise all inquired physicians, medical facilities and health insurance companies to provide Slavia pojišťovna a.s. with any and all sensitive data concerning my health condition.

Declaration:
I declare that I responded all questions truthfully and fully and I am aware of all the consequences of stating untrue information and facts as far as the obligation of the insurer to provide indemnity is concerned.

Please credit the insurance indemnity as follows

☐ To bank account in the Czech Republic		
Name of bank:		
Account No.:	Bank code:	
☐ By postal order to an address in the Czech Republic		
Name and surname:		
Street and No.:	Postal Code:	City:

In ..... on .....

Signature of the insured person or name, surname and signature of his legal representative