HEALTH ASSISTANCE AND INSURANCE CLAIM APPLICATION FORM

EUB EGYÜTTAL BIZTONSÁGBAN.

Európai Utazási Biztosító Zrt. • Általános Információ – EUB ügyfélszolgálat: 1132 Budapest, Váci út 36-38. • Tel.: +36 1 452 3580 • www.eub.hu • ugyfelszolgalat@eub.hu

Dear policy holder,

In case of an illness/accident which occured in Hungary please forward this application form to our branch at the above address together with the documents requested. Returning the entirely completed form is a basic condition of the further adjustment of your insurance claim.

Thank you for your co-operation.

To be completed by the insurance company:

Time of receipt: _____

Insurance claim number: _____

You can read detailed information about data processing practices related to your insurance policy in the Customer Information section of the Insurance Policy Conditions. The Privacy Policy of the insurance company is also available at www.eub.hu.

To be completed by the policy holder (in case of an underage policy holder to be completed by his/her legal representative):

Name of policy holder: _____ Date of birth of policy holder: ❑❑ ❑❑ ❑❑❑❑

Phone/fax number of policy holder (which facilitates contacting the policy holder): _____ Citizenship of policy holder: _____

Postal address of policy holder (in Hungary): ❑❑❑❑

Number of travel insurance policy, type of travel insurance: _____ Your e-mail: _____

In case of an UNDERAGE policy holder (who is under 18) to be completed by his/her legal representative (eg.: parent).

Data of legal representative:

Name: _____ Date of birth: _____

Address: _____ ID number: _____

I hereby certify that I am the legal representative of (name of underage person), _____ who is underage.

Type of travel: Individual ❑ Package (organised by a travel agency) ❑ Name and address of travel agency: _____

PERIOD SPENT IN HUNGARY: from ❑❑ ❑❑ 20❑❑ – to ❑❑ ❑❑ 20❑❑

Was the illness/accident reported to the EUB or EUB Assistance by telephone during the period of time spent in Hungary? Yes ❑ No ❑

If yes, when? _____ Who reported the illness/accident? _____

Country and town where the illness/accident happened: _____ Date: ❑❑ ❑❑ 20❑❑

Did you have any other travel insurance for the period of your trip with another insurance company? No ❑ Yes ❑ Name of other insurance company: _____

Do you have an insurance policy with any other insurance company which authorises you to claim damages concerning the same illness/accident? No ❑ Yes ❑

Name of other insurance company: _____

Do you have any other claim for damages towards another insurance company, company or private individual concerning the same illness/accident? No ❑ Yes ❑

To be completed only in case of an ILLNESS.

Why did you need a medical examination? _____ How many times? _____

When did you develop the symptoms? ❑❑ ❑❑ 20❑❑

When did you have the medical examination? ❑❑ ❑❑ 20❑❑ Do you suffer from a chronic disease? No ❑ Yes ❑

If yes, please specify the illness, the name of your doctor and the way he/she can be contacted: _____

Were you taken to the doctor/hospital by ambulance? Yes ❑ How many times? No ❑

To be completed only in case of an ACCIDENT.

Detailed description of accident: _____

_____ How many times did you consult a doctor? _____

Were you taken to the doctor/hospital by ambulance? Yes ❑ How many times? No ❑

Please enclose a copy of the record of the accident!

To be completed only in case of an ACCIDENT.

Registration number and make of vehicle (used for travelling): _____

Name and address of the insurance company the policy holder took out the third-party insurance policy of the vehicle with: _____

_____

Insurance policy number: _____ Is a collision damage waiver taken out for the vehicle? Yes ❑ No ❑

If yes, name of insurance company: _____ Insurance policy number: _____

Please enclose a copy of the registration document of the vehicle and the driver's driving licence, as well as a copy of the police record!

REIMBURSEMENT OF COSTS INCURRED ABROAD

(Please enclose the medical report, the original medical invoices and the certificate(s) of payment.)

☐ The person/hospital in Hungary, accepted the insurance policy, there was no need to pay for the medical treatment.

☐ **I** (or person related to me has) **paid for the** costs of the medical treatment/medicaments:

A. Costs of the medical treatment/medicaments:

	Amount:	**Currency:**	**Description:**
1.			
2.			
3.			
4.			
5.			

B. Other costs incurred in Hungary (eg.: transportation by ambulance and telephone costs):

	Amount:	**Currency:**	**Description:** *(What did the payment cover and why were the costs necessary?)*
1.			
2.			
3.			
4.			
5.			

TOTAL COSTS CLAIMED (A+B): _____ **CURRENCY:** _____

I WOULD LIKE TO CLAIM THE REIMBURSEMENT OF MY COSTS IN THE FOLLOWING WAY:

☐ **To be collected at the post office*** ***in Forints*** (Please specify the name and address of the person the claimed amount should be sent to.)

Name: _____ Address: ☐☐☐☐ _____

☐ **Through bank transfer*** ***in Forints*** ☐ ***in foreign exchange*** (the amount can only be transferred to a foreign exchange account.) ☐ Currency: _____

Name of account holder: _____

Permanent address: ☐☐☐☐ _____

Name of bank: _____ Bank account number: _____

Appendices: Travel insurance policy: _____ copies Record: _____ copies

Original invoices, certificates of payment and medical documentation: _____ copies Other documents: _____ copies

1. I, the undersigned, the holder of the insurance policy, hereby authorise the insurance company to obtain and keep a record of all the data directly related to taking out and maintaining the insurance policy, and also directly related to the service provided by the insurance company, including the data related to the insurance policy holders state of health. At the same time I hereby relieve the organisations and persons which handle my personal and health related data from their confidentiality obligation.
2. I, the undersigned, the holder of the insurance policy, hereby declare that the data provided above correspond to the facts.

****If you do not ask it for yourself, your authorization also needs a signature of two witnesses.***

Witness 1. Name: _____

Address: _____

ID number: _____

Signature: _____

Witness 2. Name: _____

Address: _____

ID number: _____

Signature: _____

Date: ☐☐☐☐☐☐ 20☐☐

_____

Signature of policy holder

(in case of an underage policy holder the signature of his/her legal representative)

To notify an insurance claim, please complete and sign the following consent form

DECLARATION FOR NOTIFYING AN INSURANCE CLAIM

I, the undersigned hereby authorize the insurance company to obtain and keep records of information about my medical conditions which directly relate to and strictly necessary for the settlement of claims arising from the insurance policy; I specifically give the insurance company consent to process my medical information so obtained for the purposes of evaluating my insurance claim.

I hereby specifically give the insurance company consent to forward information about my medical conditions which relate to the insurance policy – in particular to underwriting, claim assessment, claim settlement, co-insurance, and re-insurance – to the insurance company's parent company, to re-insurance companies established in a member state, or in the case of co-insurance to a risk sharing insurance company established in a member state, and to the outsourced medical examiners or medical facilities, which shall be deemed as domestic data forwarding.

You can read detailed information about data processing practices related to your insurance policy in the Customer Information section of the Insurance Policy Conditions. The Privacy Policy of the insurance company is also available at www.eub.hu.

Date: ❑❑ ❑❑ ❑❑ **20** ❑❑

Signature of the insured, whose personal or medical data is transferred (in the event of the insured's death, that of his/her spouse, lineal relative, sibling or life partner) Signature of the legal representative (parent, guardian) if the insured is a minor, or is a ward of state.

_____

Signature

Witness 1. Name: _____

Address: _____

ID number: _____

Signature: _____

Witness 2. Name: _____

Address: _____

ID number: _____

Signature: _____