

Insurance Claim Form

Notification of loss under accident insurance

For the purpose of quick and efficient examination of the claim, please complete the form below accurately and send directly to the address of the loss adjuster acting on behalf of AXA TUIR S.A.

Please attach the following to the form:

- medical documentation confirming the treatment (or first aid after the accident), including
 a description of bodily injury and medical diagnosis, and medical tests results and medical
 documentation on the continuation of treatment after the accident, together with results of tests
- 2. a doctor's certificate that the treatment is completed
- 3. a death certificate (if applicable)
- 4. a police report, if the accident was caused by a traffic accident
- 5. testimonies of witnesses
- 6. a photocopy of your identity document (identity card or passport)
- 7. a photocopy of the vehicle registration document and the driving licence (if applicable)

Correspondence address:

Inter Partner Assistance Polska S.A. ul. Prosta 68 00-838 Warszawa tel. +48 22 575 90 80

A. GENERAL INFORMATION			
Name and surname of the claimant (or legal guardian)			
2. Contact tel. no.			
3. Name and surname of the insured person	n		
Address			
Town/City	Post code	Street	House number/flat number
Contact tel. no.			
4. Correspondence address			
Town/City	Post code	Street	House number/flat number
5. E-mail address			
Do you consent to correspondence being s	sent to you by e-mail?		□ yes □ no
6. PESEL personal electronic identity number	er* LILILILILIL		
7. Number of the Beneficiary's bank account to which indemnity should be paid			
8. Name of the bank			
9. Name and surname of the account holder	r		
10. Instructions on the method of payment of	f indemnity	rder (please state the reside	ence address if different from the one given above)
Town/City	Post code	Street	LJLJ/LJLJ House number/flat number
11. Policy number/travel reservation number			
12. Date and place where the policy was take	en out (applies to individual	policies)	
13. Name of the travel agent – travel organize	er (applies to group policies	s under agreements with to	ur operators)
B. TRAVEL INFORMATION			
1. Time of travel			
From D.D. M.M. Y.	Y_Y_Y_ until D_D_M	MYYYY Coun	try

C. INFORMATION ON THE ACCIDENT			
1. Date of the accident DD MM YYYY time L	H _J ,H _J M _J ,M _J		
2. Place of the accident			
3. Circumstances of the accident Please give a detailed account of the event and the circumstances (if	the injury was caused while playing spor	t, please state which discipline)	
4. Description of injuries			
5. Address of the centre in Poland where the customer was treated aft	er the accident		
6. Was the treatment completed? If so, please state when.		□ yes [□ no
7. Were the police/ambulance service/other institutions (state names	and addresses) notified of the accident?		
O. Was the assistant watiful to later Darton Assistance			
8. Was the accident notified to Inter Partner Assistance?			□ no
9. Was the Insured (perpetrator) under the influence of narcotics? 10. What the least of the l			□ no
Was the Insured (perpetrator) under the influence of alcohol?		,,,,	□ no
11. Did the Insured have a blood test?		☐ yes ☐	no
D. PLEASE FILL IN THE PART BELOW ONLY IF THE INJURY WAS CAUS			
Type of vehicle by which the Insured was travelling (a passenger car,	, a bus, etc.)		
2. Was the Insured driving the vehicle?		,	□ no
3. If so, did the Insured hold an appropriate driving licence?		☐ yes	no
E. DECLARATIONS			
I acknowledge that my personal data will be processed by AXA TUIR S.A being claimed.	A. with its registered office in Warsaw, for	the purpose of adjusting the loss	S
I authorise the Company to acquire any medical information, save for res who treated me or provided me with medical advice, and also in all me Further, I agree to information on the state of my health being made av	edical centres and healthcare institutions	s where I received medical assista	ance.
I authorise the Company to obtain information in court, at the public connection with the accident or event that is the basis for establishing		e and other bodies and institution	ns in
	D D M M V V V V		
	Date Signa	ature of the Insured or attorney-in-f	fact
I hereby confirm that the information given above is true and I am aware criminally liable and may result in a refusal to pay indemnity.	that certifying an untruth or giving false	information may result in my being	g held
	D D MIM V V V		
	Date Signa	ature of the person reporting the lo	0SS

We wish to inform you that providing your personal data is voluntary but necessary for the insurance contract to be implemented and the claim to be examined (the sole purpose – data processing). The data administrator is AXA Towarzystwo Ubezpieczeń i Reasekuracji S.A. with its registered office in Warsaw, 00-867, ul. Chłodna 51. The data subject is authorised to inspect and amend his/her personal data and to lodge a written and substantiated demand that his/her personal data no longer be processed in light of his/her special situation, and to object to the processing of his/her personal data.

If you need help in filling in this form, please call +48 22 575 90 80 or write to axa-likwidacja.szkoda@ipa.com.pl.