ERGO Life Insurance SE's Estonian branch
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Registry code 12025488

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BENEFIT APPLICATION
Extra cover

The insurer is ERGO Life Insurance SE (registered in Lithuania), which offers services in Estonia through ERGO Life Insurance SE's Estonian branch.

INSURED PERSON

First and last name _____ Personal identification number _____

Address _____
Street, house, apartment (farm, village), postal code, city or municipality

Phone _____ E-mail _____

Insurance policy No. 70-5 _____ - _____

Please disburse my insurance indemnity

- ☐ Daily allowance following an accident
- ☐ Daily allowance for a day in hospital following an accident
- ☐ Disability resulting from an accident
- ☐ Extra cover for incapacity for work
- ☐ Extra cover for the daily allowance for a day in hospital following an accident
- ☐ Critical illness

The insured person's health before the insured event

The insured person's chronic illnesses and permanent conditions _____

Treatment facilities the insured person has been treated in the past two years _____

Details of the insured event

Time of the insured event _____ Time of day _____
Day, month, year

Place of the insured event _____

The insured event occurred

- ☐ at work (school) / on the way to work or back
- ☐ at a competitive sports training/competition
- ☐ during recreational sports
- ☐ due to an illness
- ☐ during leisure time
- ☐ other reason, elsewhere (where?)

Which part of the body was injured? Precise diagnosis _____

Has the part of the body that was injured been injured before? ☐ No ☐ Yes, when? _____

Detailed description of the event

Information on the incapacity for work and treatment

When did the insured person consult a doctor first after the insured event?

Day, month, year Time of day

Name, address of the treatment facility

Attending physician's name and phone

What kind of treatment did the insured person receive? Please add an excerpt from the outpatient's medical records.

Did the insured person stay in a hospital after the insured event? ☐ Yes ☐ No

If yes, please indicate until when and in which hospital. Please add an excerpt from the medical records.

Who were the other attending doctors the insured person later saw in relation to the insured event?

For how long was the insured person incapable of working as a result of the said event (how long did they miss work/school)?

Please add a document verifying temporary or permanent incapacity for work.

Was the treatment time following the insured event extended by other conditions? ☐ Yes ☐ No

If yes, which ones?

Are there any witnesses to the insured event? ☐ Yes ☐ No

If yes, please provide the name(s) and details of the witness(es) below

Was the insured person under the influence of alcohol or drugs at the time of the insured event? ☐ No ☐ Yes

If yes, please indicate the amount ingested.

Other information concerning the event

Were criminal or misdemeanour proceedings initiated following the insured event? ☐ Yes ☐ No

If yes, please add a document on the initiation/ending of the criminal or misdemeanour proceedings.

Please add the contact information of a police inspector working on the

Annexes to the benefit

- ☐ Copy of the identity document of the insured person
- ☐ Copy of emergency care document or patient record
- ☐ Excerpt from the outpatient's medical record
- ☐ Excerpt from medical records (In case of inpatient treatment)
- ☐ Copy of a certificate of incapacity for work _____ pc
- ☐ Decision on the establishment of permanent incapacity for work or decision on the assessment of the capacity for work
- ☐ Report on the workplace accident
- ☐ Police certificate
- ☐ Other documents _____ pc

Which ones? _____

_____

Please pay the money to the current account _____

The current account belongs to _____
First name and surname

I hereby confirm that the information I submitted is correct and complete. I am aware that when I have presented faulty or deficient information, the insurer has the right to reduce the benefit or refrain from paying it. I am aware that based on the provisions of the insurance contract the insurer has the right to acquire additional information concerning the insured event from the persons in possession thereof. I agree to my personal information being disclosed to an expert physician for the loss adjustment procedure. I also authorise the insurer to view the data on my health and to request additional information concerning my health on my behalf from the treatment facility where I was treated, the attending physicians and other persons in possession of information concerning my health.

INSURED PERSON OR THEIR REPRESENTATIVE

_____
First name and surname

Date _____
Day, month, year

Signature _____

RECIPIENT OF THE APPLICATION

_____
First name and surname

Date _____
Day, month, year

Signature _____