

APPLICATION FOR BENEFIT Health insurance

Insurer is ERGO Life Insurance SE (registered in Lithuania) that provides its services in Estonia through the Estonian branch of ERGO Life Insurance SE.

INSURED PERSON

Name _____ Personal ID _____

Address _____
Street, house No., apartment No. (farm, village), postal code, city or rural municipality

Telephone _____ E-mail _____

POLICYHOLDER

Name _____ Personal ID/
Reg. no _____

Address _____
Street, house No., apartment No. (farm, village), postal code, city or rural municipality

Telephone _____ E-mail _____

Insurance policy No. 70-5 _____ - _____

Benefit applicant Insured person Policyholder

Was treated Medical institution _____

Name and phone number of the physician _____

Hospital treatment, department _____ Period of time _____

Outpatient treatment _____ Period of time _____

Dental treatment _____ Date _____
Day, month, year

Applying for compensation for treatment expenses _____ euros

compensation for transport expenses _____ euros

compensation for dental treatment expenses _____ euros

compensation for medical devices _____ euros

Attachments to application for compensation

Policy

Document certifying payment of the last insurance premium (if necessary)

Copy of the document certifying identity of the insured person

Copy of the document certifying identity of the

Medical certificate/extract from the ambulatory card

Roentgenograms _____ pcs I wish them to be returned to me Yes No

Extract from the health file

Original of the treatment invoice with a receipt certifying its payment _____ pcs

Copy of the sick leave certificate _____ pcs

Invoice for medical devices

Certificate of exemption from school

Other documents _____ pcs

Please specify _____

Please transfer money to bank account No. _____

Holder of the bank account is _____
Given name and surname

I confirm that I have presented correct and complete data. I am aware that submitting wrong or incomplete data, the insurer is entitled to reduce the benefit or refuse to pay it. I am aware that based on the provisions of the conditions of the insurance contract, the insurer has the right to obtain additional information concerning the insured event from the persons in possession thereof. I agree to the forwarding of my personal data to physicians or experts for loss adjustment. I also authorise the insurer to examine the data concerning my health and request on my behalf additional information on my health from the medical institution and physicians who have treated me, as well as other persons who have information concerning my health.

POLICYHOLDER

PERSON RECEIVING THE APPLICATION

Given name and surname

Given name and surname

Date _____
Day, month, year

Date _____
Day, month, year

Signature _____

Signature _____