



Application for indemnity in travel insurance

APPLICANT

Name, Surname _____ Personal identity No: _____

Address _____ LV- _____

Phone _____ Email _____

INSURED PERSON (the injured insured person)

Policy No: _____ Valid from _____ to _____

Insurance program: ☐ Basic ☐ Standard ☐ Silver ☐ Gold ☐ Platinum

Name, Surname _____ Personal identity No: _____

Address _____ LV- _____

Phone _____ Email _____

INFORMATION ABOUT THE ACCIDENT

Date of the accident: _____, exact time, at ____ : ____ . Country: _____

City, populated area: _____

IS THE ACCIDENT REPORTED TO THE ASSISTANCE SERVICE?

☐ No ☐ Yes ☐ Smile Assistance

NATURE OF THE ACCIDENT

- | | | |
|--|--|---|
| ☐ Illness * | ☐ Trauma * | ☐ Dentistry * |
| ☐ Medical transport costs * | ☐ Purchase of medical aids * | ☐ Repatriation in case of death |
| ☐ Repatriation of a patient * | ☐ Funeral costs abroad | ☐ Transport and residence costs for one relative |
| ☐ Organization of meeting in the home country * | ☐ Death caused by an accident | ☐ Permanent disability caused by an accident |
| ☐ Passport insurance | ☐ Informative assistance | ☐ Civil liability |
| ☐ Transport accident * | ☐ Travel cancellation * | ☐ Travel termination * |
| ☐ Delay of a trip * | ☐ Being late for a trip | ☐ Loss of luggage |
| ☐ Damage of luggage | ☐ Delay of luggage | ☐ Theft of luggage |
| ☐ Breaking of sports equipment | ☐ Damage of sports equipment | ☐ Delay of sports equipment |
| ☐ Theft of sports inventory | ☐ Difference of flights | ☐ Chemical cleaning and repair of clothing |
| ☐ Medical costs in the home country * | ☐ Legal costs | ☐ Substitution of the insured person * |
| ☐ Other (indicate) _____ | | |

* If accident marked with * and requests health data processing, then insured person has to fill in page 3 in this application form

**DESCRIPTION OF THE ACCIDENT** (In detail and in chronological order)**WERE YOU UNDER THE INFLUENCE OF ALCOHOL OR OTHER DRUGS AT THE TIME OF THE ACCIDENT?**☐ No ☐ Yes**FIRST AID**

Date: _____ Time: ____ : ____ . Medical treatment institution _____

PERSONALLY COVERED CHARGES☐ No ☐ Yes ☐ If Yes, specify the amount _____**PLEASE PAY THE INSURANCE IDEMNITY BY A TRANSFER**

Beneficiary _____

Personal identity No / Reg. No of the beneficiary _____ Bank name: _____

Account No.: _____

THE DOCUMENTS ATTACHED TO THE APPLICATION (mark the necessary with "X")

☐ Medical documentation:	☐ Receipts (specify quantity) _____	☐ Prescriptions (specify quantity) _____
☐ Travel documents:	☐ Tickets	☐ Statement from the carrier
☐ Invoices		
☐ Other documents (specify the tipe and quantity) _____		

PLEASE INFORM ME OF THE DECISION ON INSURANCE COMPENSATION:

☐	In writing by mail to the following address:
☐	In writing to the following e-mail address:
☐	Verbally by calling the following phone number:
☐	Text message to the following phone number:

BY SIGNING THIS APPLICATION I CONFIRM

The aforementioned information is true.

I am informed that in case of provision of false information IJSC "Baltijas Apdrošināšanas Nams" has the right not to pay an insurance indemnity and I may be held liable in accordance with the procedure prescribed in the regulatory enactments of the Republic of Latvia.

IJSC "Baltijas Apdrošināšanas Nams" will process your personal data for the purpose of executing an insurance contract in accordance with the requirements of the regulatory enactments of the European Union and the Republic of Latvia regarding the protection of personal data. Additional information about the processing of personal data <https://www.ban.lv/kompanija/privatuma-politika/>.**APPLICANT'S SIGNATURE AND APPLICATION DATE**

First and last name _____ Date: _____



Consent for the health data processing

You have the right to disagree and not sign this form, but in this case, the insurer will not be able to provide insurance services and consider application for indemnity.

I, _____, _____
/ name, surname / / personal identity No /

agree with the processing of

☐ my

☐ my child _____, _____
/ name, surname / / personal identity No /

personal data, including special category (sensitive) personal data concerning health.

Allow IJSC "Baltijas Apdrošināšanas Nams" to receive personal data, including special category data and medical documentation (including information about diagnosis, history of disease and previous treatment, results of confirmatory examinations, received treatment and duration of treatment, prescribed and purchased medicines, etc.), from other legal or natural persons, including medical treatment institutions and medical practitioners, with a purpose to ensure the execution of an insurance contract and obtain information to ensure the extent of insurance protection.

I confirm that I am informed about IJSC "Baltijas Apdrošināšanas Nams" Privacy policy and rights to withdraw consent any time. I am informed that in the case of a cancellation of consent, the IJSC "Baltijas Apdrošināšanas Nams" will not be able to comply with the purpose for which such consent was obtained and will not provide insurance services.

PLACE AND DATE:

Place: _____, Date: _____

APPLICANT'S SIGNATURE

Name, surname