5 Request

for

PAYMENT OF INSURANCE INDEMNITY UNDER PERSONAL ACCIDENT AND SICKNESS INSURANCE

BULSTRAD
VIENNA INSURANCE GROUP

To ....

....

(insurance company)

A. Details of the Claimant / Authorized person with POA

Name.. Personal ID ☐☐☐☐☐☐☐☐☐☐

☐ natural person ☐ authorized person /with POA No ..../.......................................

Address: res. area, street .... City ....

ID card .... e-mail.. Tel:..

B. Details of the Insured

Name.. Personal ID/Bulstat: ☐☐☐☐☐☐☐☐☐☐

Address: res. area, street .... City ....

ID card .... e-mail.. Tel:..

Insurance policy No:.. Covers/Clauses:..

C. Details of the Injured/Affected Person

Name.. Personal ID ☐☐☐☐☐☐☐☐☐☐

Medical center where first aid was provided:.. on date..

Address: res. area, street .... City ....

Name, address, tel. of general practitioner..

Brief description of injuries ....

....

Brief description of sickness ....

Name and address of employer ....

Have you filed an insurance claim with another insurance company for compensation of your injuries/condition? ☐ yes ☐ не

If YES, please provide accurate information:

Nature of incurred loss: ☐ monetary ☐ personal injury ☐ driver of vehicle ☐ passenger in vehicle

☐ sickness ☐ labor accident ☐ non-labor accident

Sick leave period: from......................... to......................... Health insurance No ....

Hospital stay .... Home treatment ....

D. Incurred expenses

Description of expenses incurred for medical treatment and recovery:

....

....

....

....

....

E. Date, place and circumstances / causes of the occurrence:

....

....

....

....

....

....

F. Witnesses of the occurrence/accident

Name..	Name..
Address	Address ....
City .... Tel.:.........................	City .... Tel.:.........................

REQUEST

In case of insurance event
0800 11 111

Information on the way we process your personal data and your rights in this regard can be found on the Company's website: www.bulstrad.bg

BULSTRAD VIENNA INSURANCE GROUP
1000 Sofia, 5 Positano Sq. • Tel.: 02 9856610
UIC 000694286 • License of insurance activity No. 11/16.07.1998

230829

G. In case of death due to sickness/personal accident

Heirs:

Name.. Personal ID [| | | | | | | | |]
Address.. Tel.: ....

Name.. Personal ID [| | | | | | | | |]
Address.. Tel.: ....

Name.. Personal ID [| | | | | | | | |]
Address.. Tel.: ....

Name.. Personal ID [| | | | | | | | |]
Address.. Tel.: ....

H. Declaration of Claimant/Insured:

I/we declare that the answers and data provided by me/us above is true and complete and I/we give my/our consent that Bulstrad Vienna Insurance Group may use the data in connection to the procedures and administration of my/our claim for insurance indemnity. I/we are aware of the liability I/we bear for provision of false data, according to Art. 313 of the Penal Code.

Signature:.................................... Date:.................................... Signature:.................................... Date:....................................
Injured person Authorized person

I. Documents necessary for filing a claim:

Submitted documents shall be marked with **X**, requested document shall be circled with **O**

1. ☐ Discharge summary (epicrisis)	12. ☐ Findings report of a labor accident
2. ☐ Medical leave note .... (number of notes)	13. ☐ Declaration of a labor accident
3. ☐ X-ray images .... (number of images)	14. ☐ Record of a labor accident
4. ☐ Outpatient visit report from attending physician	15. ☐ Order of the National Social Security Agency
5. ☐ Personal outpatient card – copy	16. ☐ Conclusive report
6. ☐ Decision of a Labor Expert Medical Commission	17. ☐ Death certificate
7. ☐ Other medical documents	18. ☐ Certificate of heirs
8. ☐ Record of first aid provided	19. ☐ Autopsy report
9. ☐ Findings report from a traffic accident	20. ☐ Other documents
10. ☐ Results from an alcohol blood test	21. ☐ Original copies of invoices for incurred expenses
11. ☐ Note/record from employer	22. ☐ Bank account certificate for the IBAN number

K. Indemnity

I would like to receive insurance indemnity at the following bank account:

IBAN.. BIC.. with bank.. branch..

I will certify the above IBAN by submitting a copy of a bank account certificate.

City .... Date.. For the injured person..
(Last name and signature of the authorized person)

Most recent documents submitted on.. by..
(Given, middle and last name and signature of the authorized person)

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