UNIQA
Osiguranje nove generacije.

UNIQA neživotno osiguranje a.d.
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Voluntary health insurance

Insured case report

Policy number

Damage number | Policy number | ID Document number

Insurance contractor

Surname, name / Name of the legal entity | Broj telefona

Zip Code | Place, street and number

Insured person

Surname, name | Personal ID No.

Zip Code | Place, street and number

Occupation | e-mail | Telephone number

In which organization he/she is employed, is a member

What work does he/she does in that organization (exact job description)

Insured event data

Date of occurrence of the insured event — dan | 0 8 mjesec | godina

In which health institution did you receive treatment for this insured event?

Please state the cause of the insured event:

Please provide a given diagnosis:

Amount of total costs:

I declare that I have answered all the questions truthfully and completely.

I declare that I agree that the Insurer - UNIQA non-life insurance a.d. - in the process of resolving the compensation claim, if deemed necessary, has the right to inspect all documentation and obtain information from third parties about the current and previous health status of the Insured (health card, reports of specialist surgeries, cards - medical history in hospitals, etc.).

In _____, date _____ year.

Pay the indemnity to the account _____ (Bank account number), at _____ (Name of the bank)

Signature of the Insured - the beneficiary of the insurance

101-2101

X Odgovarajuće označite

Employer's certificate (only in the case of collective insurance)

1. _____ has been employed continuously since _____ year.
(Name and surname of employed person)

The employee does the work _____
(occupation)

2. Until the day of registration of the insured event, he has not stated that he does not want to be insured.
3. He is insured with a voluntary health insurance policy: _____

4. Until the day of the insured event, the premium is paid for the month _____ in the amount of _____ EUR, that is, for the total number of insured members in the total amount of _____ EUR.

The correctness and truthfulness of the stated data is confirmed by the Insurance Contractor.

In _____, date _____ year.

_____
Stamp and signature of the Insurance Contractor

Necessary documentation:

1. Insured Case Application Form
2. Medical report with the stated diagnosis
3. Prescribed prescription for medicines / aids
4. Original invoice for medical services
5. Photocopy of the voluntary health insurance document
6. Photocopy of ID card
7. Photocopy of the current bank account of the insured - beneficiary of the insurance

Note: The Insurer has the right to request additional documentation from the Insured, the Insurance Contractor or any legal or natural person.

X Odgovarajuće označite