SIGNAL IDUNA
UBEZPIECZENIA

GENERAL PERSONAL ACCIDENT CLAIM

Please, complete the present form carefully and send it directly to the address of SIGNAL IDUNA Polska TU S.A. or via the travel office. You are requested to deliver the following additional documents:

1. Insurance policy (does not apply to the general agreements),
2. Medical first aid documentation including description of the bodily injuries and the medical diagnosis and tests results,
3. Medical post-accidental treatment documentation incl. tests results.

Additionally, depending on the art of claims please add the following documents:

1. Police report drawn up at the place of accident,
2. Statements of the witnesses,
3. Death certificate,
4. Other documents confirming the reported claims.

Address:

SIGNAL IDUNA Polska TU S.A.
Zespół Obsługi Roszczeń Turystycznych
ul. Przyokopowa 31, 01-208 Warszawa; Tel. 22 505 61 60

PERSONAL DATA OF INSURED

1. Name and Surname

2. Address ....
postal code city street telephone number

3. Correspondence address: .....

4. E-mail:

5. Date of birth: D D M M Y Y Y Y ....
day month year parents names occupation

Do you agree to have the correspondence re. the notified claim sent (e-mail, sms?) ☐ Yes ☐ No

DATA OF POLICY

6. Policy number: ..... valid from D D M M Y Y Y Y until D D M M Y Y Y Y
day month year day month year

7. Policyholder /Travel office: .....

INFORMATION ON CLAIM

8. Accident: D D M M Y Y Y Y T T
day month year time

9. Place of accident: .....

Address: .....

10. Detailed description of the accident, incl. the bodily injuries:

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.....

SJT 0128/7.14

11. Was the Insured sober at the moment of the accident ☐ Yes ☐ No

12. Names and addresses of the medical providers where the Insured had been treated before the accident:

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13. Names and addresses of the medical providers where the Insured had been treated after the accident:

.....

.....

14. Name and surname of the GP: .....

.....

15. In the case of an car accident please provide the license number and the police station the accident was reported to:

.....

16. In the case the Insured was driving the car at the moment of the accident, please provide the number and the category of the driving license:

.....

17. Where and by whom the Insured was given the first medical aid?

.....

18. Has the after-accident-treatment and rehabilitation been already finished? ☐ Yes ☐ No

(If not, please provide the possible date of closing treatment, if known) .....

19. Names and surnames and addresses of the witnesses:

.....

.....

20. In the case of the death of the witness please provide the personal data and address of the person who files a claim.

.....

DECLARATION

1. By signing this claim form, I certify that all information given above is true and complete to the best of my knowledge.
2. I consent my personal medical records to be disclosed by the physicians who treat me and to be passed the medical documentation including that information through to the physicians working for SIGNAL IDUNA Polska TU S.A.
3. I consent my personal medical records to be disclosed by the public and non public medical providers as well as the PZU (Polish Insurance Company) and to be accessible to the physicians of SIGNAL IDUNA Polska TU S.A.

CLAIMS PAYMENT

The due reimbursement shall be delivered to the following PLN bank account:

No. ☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Name and the no. of the bank branch: .....

Name and surname of the bank account owner: .....

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Date and signature of the Policyholder/ Office travel clerk

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Date and signature of the Insured