

Chubb European Group SE Spółka Europejska Oddział w Polsce ul. Królewska 18 00-103 Warszawa, Polska T + 0 801 800 028 www.chubb.com.pl

Claim form - Personal accident and Critical Illness

Please complete this form as thoroughly as possible and deliver directly to the address of Chubb European Group SE Branch in Poland, ul. Królewska 18, 00-103 Warszawa, with the annotation "Chubb-Claims Departament" or by e-mail to address: szkody@chubb.com

Policy details			
1.	Policy no:		
2.	Insurance period from: to:		
То	be filled by the Employer:		
3.	Employment (name of the workplace and address):		
4.	Employment period from: to:		
5.	Position:		
6.	Certification of the workplace (stamp of the workplace and signature of an authorized person):		
7.	Date of completion:		
Insured's personal data			
8.	Name and surname:		

Chubb European Group SE European Company Branch in Poland, whose registered office is in Warsaw, address: ul.Królewska 18 00-103 Warsaw, registered in the Register of Entrepreneurs kept by the District Court for the City of Warsawin Warsaw, XII Commercial Division of the National Court Register under the company number KRS 0000233686, Taxpayer Identification Number (NIP) 1080001001, statistical number (REGON) 140121695, notified to the Polish Financial Supervision Authority. Chubb European Group SE is an insurance undertaking governed by the provisions of the Frenchinsurance code, registered in Commerce and Companies Registry (Registres du Commerce et des Sociétés – RCS) in Nanterre with registration number 450 327 374 and with the registered office in France, address: La Tour Carpe Diem, 31 Place des Corolles, Esplanade Nord, 92400 Courbevoie, France. Chubb European Group SE has fully paid share capital of C896,176,662.

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9.	Adress:			
	Post code	city	street	
10.	Correspondence adress:			
11.	Telephone number:			
12.	E- mail adress:			
13.	PESEL:			
Ins	sured event data			
14.	Date of loss:	day month	year	
15.	Place of accident:			
16.	Detailed description of the circumsta	nces of the accident and the occurr	ence of personal injuries	s:
17.	Please, mark with a cross the nature	of the accident:		
	death permanent inabili	ty for work temporary in	ability for work	broken bones
	permanent detriment to health	body burns	coma	hozpitalization
	orphaning fu	uneral cost	re-qualification cost	
	concurrent death of Insured and	his/her life partner Home h	nelp costs	
	costs of adjustment or change of	residence medical expenses	s	
	heart attack stroke	critical illness		

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18.	Was the police or prosecutor present in the place of accident and is this a subject of their investigation? If yes, please note the name and address of the police and/or prosecutor's department and the documents reference no:				
	Yes No				
19.	Was the Insured under the influence of alcohol or any other intoxicating substance when the accident happened? Yes No				
20.	Names and addresses of medical facilities where the insured was treated before the accident in the last 5 years:				
21.	Who and where provided the insured with first medical aid after the event?				
22.	If there are witnesses to the event, give surnames and first names and their addresses:				
23.	In case of death of the Insured, please provide name and address of the claimant:				
Bei	nefit payment				
Ben	efit to be transfered to the bank account no:				
Ban	k name and branch:				
Nan	ne and surname of the bank account owner:				

Date and Insured's signature

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Statement

- I declare that all information provided by me in this application is complete, true and given to the best of my knowledge. I am aware that I am liable under the law for making false statements made to obtain an undue financial benefit.
- 2. I hereby give permission for Chubb European Group SE Spółka Europejska Oddział w Polsce (Societas Europea Branch in Poland) to ask entities conducting medical activity for information regarding the circumstances associated with underwriting, verification of the data that I have provided concerning my health, and determination of my right to a benefit under the insurance contract and the amount of that benefit, i.e. information indicated in Article 38 secs. 1-7 of the Act of 11 September 2015 on Insurance and Reinsurance Activity.
- 3. I hereby give permission for providers of medical services to make available to Chubb European Group SE Spółka Europejska Oddział w Polsce (Societas Europea Branch in Poland) medical documentation about my health and medical services that I have received, in accordance with Article 26 sec. 3(7) of the Act of 6 November 2008 on patient's rights and the Patient's Rights Ombudsman.
- 4. I hereby give permission for Chubb European Group SE Spółka Europejska Oddział w Polsce (Societas Europea Branch in Poland) to request from the National Health Fund and obtain from the National Health Fund, in accordance with Article 38 sec. 8 of the Act of 11 September 2015 on Insurance and Reinsurance Activity), information on the names and addresses of providers of medical services that provided me with medical health services in relation to an accident or a fortuitous event that is the basis for determining the liability of Chubb European Group SE Spółka Europejska Oddział w Polsce (Societas Europea Branch in Poland) and determining the amount of the compensation or other benefits.

I hereby agree to communicate regarding a claim via e-mail, using the e-mail address provided by me.			
□ Yes □ No			
We use personal information which you provide to us for the issue of the policy, policy administration, claims management, and other insurance purposes, as further described in our Master Privacy Policy, available here. [https://www.chubb.com/uk-en/footer/privacy-policy.html]			

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Insured's signature