

Incoming No	
Date	

Claim Form №

Reimbursement of Expenses under Group Health Insurance "Bulgaria Zdrave"

Name PIN/ID

(First name, Middle name, Family name)

Correspondence address:

..... Telephone/Mobile: e-mail:

In its capacity as: Insured person Parent/Guardian of the Insured person
 Legal representative of the Insured person

I declare that I am Parent/Guardian of the Insured person and I exercise parental rights over:

..... PIN/ID

(First name, Middle name, Family name)

Policy Holder/Employer: Health card №

The insurance claim arised on the occurrence of: illness accident pregnancy child delivery other

Please describe in detail the circumstances and reasons for the occurrence of the claim:

.....

.....

I hereby claim a reimbursement for healthcare benefits and/or services expenses at the amount of:..... BGN.

I present the following documents: (please mark with "x")

- | | |
|---|--|
| <input type="checkbox"/> Ambulatory sheet or other document, certifying an examination by a specialist pcs. | <input type="checkbox"/> Copy of Team Selection Statement |
| <input type="checkbox"/> Epicrisis (in case of hospital treatment) № | <input type="checkbox"/> An expert decision of the TEMB or NEMB (TELK/NELK commission) |
| <input type="checkbox"/> Epicrisis (in case of sanatorial treatment) № | <input type="checkbox"/> Sick note pcs |
| <input type="checkbox"/> Investigative test results pcs | <input type="checkbox"/> Physiotherapy Card for prescribed procedures |
| <input type="checkbox"/> Interpretation of medical imaging tests pcs | <input type="checkbox"/> Stickers of the purchased dioptric glasses/contact lenses |
| <input type="checkbox"/> X-ray pcs | <input type="checkbox"/> Panoramic X-ray verifying dental status from first visit to the dentist |
| <input type="checkbox"/> Stickers of medical devices and appliances if used..... pcs | <input type="checkbox"/> Sector X-ray |
| <input type="checkbox"/> Prescription pcs, Original pcs | <input type="checkbox"/> Original invoice, accompanied by a fiscal receipt..... pcs |
| <input type="checkbox"/> Copy of prescription book № | <input type="checkbox"/> Other documents |

I declare that I want the approved amount to be paid to my bank account:

IBAN:, BANK NAME,

** I have been informed that I must provide my personal bank account and that I am entitled to receive insurance compensation in person.*

In case the provided bank account is held by another person, I declare that he/she is:

Account Holder:

I declare that I would like all further correspondence concerning the present claim to be send at the contact details given above and to be held via chosen by the Insurer correspondence channel. By providing a mobile phone number and email address, I agree to receive text messages regarding the review of my claim for reimbursement of expenses.

I, the undersigned Insured/ the Legal Representative of the Insured, declare that:

- I have been informed that the personal data I provide (including that of the other persons insured) are processed by Bulgaria Insurance AD, in its capacity of a personal data controller, under the current legislation and I am aware, as well as the other insured persons with the Privacy Notice under Art. 13 and Art. 14 of Regulation (EU) 2016/679, published on www.bulgariainsurance.bg and available in its offices.
- I agree and give my explicit consent that Bulgaria Insurance AD may process for the purposes of the insurance contract the personal data provided by me of minors of age insured persons.
- No other claim has been lodged regarding the above stated insurance event and no insurance compensation has been paid to me by other Insurers or institutions.
- I have been informed that information concerning the status for each claim is contained in my online file in the Insurer's electronic system, available on www.bulgariainsurance.bg/вход_за_клиенти.
- I have been notified, that according to Art. 108, para. 1 of the Insurance Code, the Insurer will make a decision within 15 working days, from the date of submission of the last required document.

Date:

Signature: