

**Application for health
insurance claim****INFORMATION ON THE INSURED PERSON**

Name, surname	<input type="text"/>	Phone	<input type="text"/>
Personal identity number/ID number	<input type="text"/>	Insurance card or policy No.	<input type="text"/>
E-mail address	<input type="text"/>	Policyholder (Company/employer)	<input type="text"/>
The actual address of the place of residence	<input type="text"/>	LV-	<input type="text"/>

INSURANCE CASE (please mark received service and indicate number of submitted documents)

<input type="checkbox"/> Outpatient treatment <small>(number of doc.)</small>	<input type="checkbox"/> Pregnancy care, childbirth <small>(number of doc.)</small>	<input type="checkbox"/> Dentistry <small>(number of doc.)</small>	<input type="checkbox"/> Vaccination <small>(number of doc.)</small>
<input type="checkbox"/> Inpatient treatment <small>(number of doc.)</small>	<input type="checkbox"/> Outpatient rehabilitation <small>(massage, recreative gymnastics)</small> <small>(number of doc.)</small>	<input type="checkbox"/> Acquisition of optics <small>(number of doc.)</small>	<input type="checkbox"/> Mandatory health check <small>(number of doc.)</small>
<input type="checkbox"/> Acquisition of medicinal products <small>(number of doc.)</small>	<input type="checkbox"/> Rehabilitation in sanatorium <small>(number of doc.)</small>	<input type="checkbox"/> Sports <small>(number of doc.)</small>	<input type="checkbox"/> Other <small>(number of doc.)</small>
Total amount of the expenses EUR		<input type="text"/>	
		<small>(amount in words)</small>	

Serious/Critical Illness insurance

<input type="checkbox"/> Outpatient treatment <small>(number of doc.)</small>	<input type="checkbox"/> Inpatient treatment <small>(number of doc.)</small>	<input type="checkbox"/> Medicinal products <small>(number of doc.)</small>	<input type="checkbox"/> Rehabilitation in sanatorium <small>(number of doc.)</small>
Total amount of the expenses EUR		<input type="text"/>	
		<small>(amount in words)</small>	

Travel insurance
 Medical expenses
(number of doc.)
Accident insurance
 Invalidity
(number of doc.)
 Death
(number of doc.)
SHORT DESCRIPTION ON CONDITIONS RESULTING IN INSURANCE CASE

(chronic disease, diagnosis, household trauma, occupational injury, road accident, sports injury etc.)

PLEASE PAY INSURANCE COMPENSATION BY TRANSFER

(In case other person is authorized for receiving compensation, application must be supplemented with written power of attorney)

To my bank account:

Account No	<input type="text"/>	Bank	<input type="text"/>
Name, surname of account holder	<input type="text"/>	Personal identity number	<input type="text"/>

To the trust's bank account (according to the power of attorney attached to the application form)

Account No	<input type="text"/>	Bank	<input type="text"/>
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 By completing and sending the claim for indemnification, I certify that:

- the above data is my personal data, and I shall not make any claims to the Insurer by choosing to complete and submit this application to the Insurer if, in the case of doubt as to the identity of the person completing this application or correctness of other information, the Insurer requests additional information or actions taken by me for the confirmation or specification of the information specified in the application;
- I have read the Insurer's Privacy Policy for the Processing of Personal Data published on the Insurer's website <https://www.ergo.lv/lv/par-ergo/privatuma-politika>, and it is also made available at the Insurer's sales points;
- I am aware that the Insurer is entitled to process my health data by requesting and receiving information and documents from the medical institutions and other persons for the purpose of clarifying the circumstances of the insured event and making a decision on indemnification claims;
- the above information is true, and I understand that by providing false or misleading information, the Insurer has the right not to pay the insurance indemnity, terminate the insurance contract and I can be held liable in accordance with the procedure prescribed by the laws and regulations of the Republic of Latvia;
- I shall not claim any compensation from other institutions for the part of the expenses reimbursed by the Insurer, as well as shall keep the originals of the documents certifying the payments made to me for 3 (three) years and present them to the Insurer immediately upon request.

I agree that ERGO will send all information related to the compensation case to an e-mail Yes No

Date of submission of the application	<input type="text"/>	Signature	<input type="text"/>
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FILLED BY INSURER'S EMPLOYEESInsurance case No.

Total payment LVL	<input type="text"/>	Date	<input type="text"/>	Signature	<input type="text"/>
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