KINDLUSTUSANDJA
ERGO Life Insurance SE Eesti filiaal
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Registrikood 10017013

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ERGO

APPLICATION FOR BENEFIT
Health insurance

Insurer is ERGO Life Insurance SE (registered in Lithuania) that provides its services in Estonia through the Estonian branch of ERGO Life Insurance SE.

INSURED PERSON

Name _____ Personal ID _____

Address _____
Street, house No., apartment No. (farm, village), postal code, city or rural municipality

Telephone _____ E-mail _____

POLICYHOLDER

Name _____ Personal ID/ Reg. no _____

Address _____
Street, house No., apartment No. (farm, village), postal code, city or rural municipality

Telephone _____ E-mail _____

Insurance policy No. 70-5 ____ - _____

Benefit applicant ☐ Insured person ☐ Policyholder

Was treated Medical institution _____

Name and phone number of the physician _____

Hospital treatment, department _____ Period of time _____

Outpatient treatment _____ Period of time _____

Dental treatment _____ Date _____
Day, month, year

Applying for
☐ compensation for treatment expenses _____ euros
☐ compensation for transport expenses _____ euros
☐ compensation for dental treatment expenses _____ euros
☐ compensation for medical devices _____ euros

Attachments to application for compensation

☐ Policy
☐ Document certifying payment of the last insurance premium (if necessary)
☐ Copy of the document certifying identity of the insured person
☐ Copy of the document certifying identity of the
☐ Medical certificate/extract from the ambulatory card
☐ Roentgenograms _____ pcs I wish them to be returned to me ☐ Yes ☐ No
☐ Extract from the health file
☐ Original of the treatment invoice with a receipt certifying its payment _____ pcs
☐ Copy of the sick leave certificate _____ pcs
☐ Invoice for medical devices
☐ Certificate of exemption from school
☐ Other documents _____ pcs

Please specify _____

Please transfer money to bank account No.

Holder of the bank account is _____
Given name and surname

I confirm that I have presented correct and complete data. I am aware that submitting wrong or incomplete data, the insurer is entitled to reduce the benefit or refuse to pay it. I am aware that based on the provisions of the conditions of the insurance contract, the insurer has the right to obtain additional information concerning the insured event from the persons in possession thereof. I agree to the forwarding of my personal data to physicians or experts for loss adjustment. I also authorise the insurer to examine the data concerning my health and request on my behalf additional information on my health from the medical institution and physicians who have treated me, as well as other persons who have information concerning my health.

POLICYHOLDER

_____
Given name and surname

Date _____
Day, month, year

Signature _____

PERSON RECEIVING THE APPLICATION

_____
Given name and surname

Date _____
Day, month, year

Signature _____