Insurance Claim Form

for Accident, Health and Life Insurance policies, and
for Property Insurance policies with accident, health and life insurance add-ons

GENERALI

Generali Biztosító Zrt. • Customer Service Direct Line: +36 1 452 3333 • generali.hu/kapcsolat

Policy number(s) on which you intend to make a claim

Policy number: . . . . . Policy number: . . . . .

The Policyholder (If the policyholder and the insured are the same person, only the insured's details need to be filled in.)

Policyholder's name: . . . . . Mobile/landline phone: . . . . .

Place and date of birth: . . . . . Email address*: . . . . .

Address: . . . . .

The Insured

Insured's name: . . . . . Phone: . . . . .

Place and date of birth: . . . . . E-mail address*: . . . . .

Mother's maiden name: . . . . . Occupation: . . . . .

Address: . . . . . Job description: . . . . .

The insured's current sporting activities (what sports do you do?): . . . . .

At what level? ☐ Top international athlete ☐ Top national athlete ☐ Athlete competing at regional level

☐ Athlete competing at local level ☐ Recreational athlete ☐ Do not do sports

The insured's former sporting activities (what sports did you do?): . . . . .

How long and at what level (based on the classification above) have you been doing sports? . . . . .

The Claimant (To be filled in only if the claimant is not the insured person.)

Claimant's name: . . . . . Telephone: . . . . .

Place and date of birth: . . . . . E-mail address*: . . . . .

Address: . . . . .

Legal Representative (parent, guardian, trustee) of a Minor Beneficiary/Insured Person

Name: . . . . . Telephone: . . . . .

Place and date of birth: . . . . . E-mail address*: . . . . .

Address: . . . . .

. . . . .
Signature of Beneficiary/Legal Representative

* Please, use the email address provided herein for communication purposes.

Form No.: 23168

Date: . . . . .

. . . . .
Signature of Claimant

Policy number: . . . . . Policyholder's name: . . . . . .

The Beneficiary (To be filled in and signed by the beneficiary!)

☐ Beneficiary entitled to receive benefits due in the lifetime of the insured (the insured in the absence of a named beneficiary)

☐ Death beneficiary

Beneficiary's name: . . . . . Telephone: . . . . . .

Place and date of birth: . . . . . Email address*: . . . . . .

Address: . . . . . Bank account number: . . . . . .

. . . . . .
Signature of Beneficiary/Legal Representative

Please be informed that the death benefit can only be paid after the due diligence of the beneficiary entitled to the benefit, the policyholder customer and the holder of the bank account other than the beneficiary of the payment has been completed in accordance with Act LIII of 2017 on the Prevention and Combating of Money Laundering and Terrorist Financing. Please contact our customer service in person or by phone to arrange a due diligence.

Account holder, if different from the death beneficiary:

Account holder's name: . . . . . .

Place and date of birth: . . . . . .

Mobile number**: . . . . . .

Bank account number: . . . . . .

. . . . . .
Signature of Beneficiary/Legal Representative

* Please, use the email address provided herein for communication purposes.

** Providing the account holder's telephone number can speed up the due diligence process and therefore the payment process by allowing us to contact the account holder directly by telephone to carry out the due diligence. Please do not fill in the telephone number unless you have agreed with the account holder in advance and the account holder has expressly given his/her consent.

To be completed in the event of an accident!

The accident occurred on: . . . . . year . . . . . month . . . . . day, ... hours

The exact location of the accident: . . . . . .

How did the accident happen and what injuries did the insured suffer? A detailed description of the event: . . . . . .

Had the body part that was injured in the accident been previously injured as a result of an earlier accident or disease? ☐ yes ☐ no

. . . . . .

What is the insured event underlying the insurance claim? (Please, mark with an X!)

Life, Accident and Health Insurance

☐ Bone fracture
☐ Soft tissue injury
☐ Permanent disablement as a result of an accident or road accident
☐ Accidental incapacity to work, or incapacity to work
☐ Permanent disablement (disability/impaired earning capacity)
☐ Accidental surgical benefit, surgical benefit, accident recovery benefit, recovery benefit
☐ Accidental hospitalization with daily payment, hospitalization with daily payment, burns benefit
☐ Critical illness
☐ Malignant tumors
☐ Tumor diagnostics
☐ 40 critical illness
☐ Death, accidental death, or death as a result of a road accident
☐ Reimbursement of accident expenses
☐ Early partial payout

Fee-for-service Health Insurance

☐ Treatments prepaid by the Insured

Policy number: . . . . . Policyholder's name: . . . . . .

DECLARATIONS

☐ By virtue of signing this form, I hereby authorize the insurance company to obtain, process and keep records of information directly related to the insured's medical conditions which are strictly necessary for the conclusion, modification and maintenance of the insurance policy referred to above (or the insurance coverage of the particular insured under a group policy; hereinafter jointly referred to as: insurance policy) as well as for the assessment of claims arising from the insurance policy and their settlement.
I specifically authorize the insurance company to process and use the health data of the insured person disclosed at the time when this declaration is executed or any time before or after it, or otherwise obtained (made available to the insurance company) for the purposes of managing the insurance policy referred to above.
Please note that the processing of your health data may be based on your explicit consent, so please indicate your consent by ticking the box above in order to have your insurance claim assessed.

☐ By virtue of signing this form I hereby specifically agree that to the extent necessary for underwriting, claims assessment, claims settlement, co-insurance, and re-insurance related to this insurance policy, the insurance company may forward the insured's protected health information to its parent company, to any re-insurance company seated in a member state, or in the case of co-insurance to a risk sharing insurance company seated in a member state, or for the purposes of medical management services to the designated health care provider and/or to the medical management service provider as well as to any of its contracted partners providing medical and health services, in compliance with the provisions on the confidential treatment of insurance information.
In compliance with data protection regulations, the insurance company may disclose protected health data and confidential data related to insurance to the data processor, or to its contracted experts (physicians, medical experts, health care service providers) within the framework of outsourcing activities, for the purposes of preparing expert opinions as required for underwriting and the settlement of claims.

☐ I hereby consent that Generali Biztosító Zrt. may inform the policyholder, or the acting Insurance Intermediary about any insurance claim I have notified, the type of benefit claimed, the acceptance or rejection of such claim, the amount of benefit payout made in respect of the claim, provided that such information is specifically requested by the policyholder.

☐ By virtue of signing this declaration, I hereby consent to be delivered by Generali Biztosító Zrt. all communications related to this insurance electronically, including notification about the conclusion and cancellation of coverage, information about insurance claims, claim settlement and loss prevention, to the email address I specify on this insurance claim form.

DATA PROCESSING

Personal data will be processed on behalf of Generali Biztosító Zrt (registered seat: 1066 Budapest, Teréz krt. 42-44.), the **data controller.**

The purposes of the processing:

a) keeping records of, and handling administrative matters concerning the insurance policy;
b) processing and assessing insurance claims made on the insurance policy;
c) preventing and combating the fraudulent use or abuse of insurance policies so as to protect the interest of the insurance pool;
d) preventing and combating money laundering and terrorist financing, complying with international sanctions, and establishing tax residence, if the insurance policy includes a life insurance risk;
e) preventing and combating the financing of terrorism, and complying with international sanctions, if the insurance policy covers only non-life risks;
f) handling of complaints.

The law grants you certain rights in respect of the personal data we hold about you

You have the right to obtain from the Company confirmation as to whether or not your personal data are being processed, and, where that is the case, access to the personal data. You have the right to obtain from the data controller the rectification of inaccurate personal data concerning you, or in the cases specified in legislation, the erasure of your personal data or restriction of processing of your data; you shall also have right to data portability. Where processing is based on your consent, you have the right to withdraw your consent at any time.
You have the right to object to the processing of your personal data for direct marketing purposes, or to data processing based on a legitimate interest of the data controller. If a complaint or request concerning the processing of your personal data could not be resolved to your satisfaction, or you believe that the processing of your personal data infringes the law, you are entitled to lodge a complaint with the National Authority for Data Protection and Freedom of Information.
If your rights to the protection of your personal data are infringed, you have the right to take legal action.

Detailed Information on Personal Data Processing

The detailed rules of data processing for the purposes specified above, as well as the list of data processors engaged, and the rights and remedies related to the processing of personal data are set out in the Insurance Company's data privacy notice.

To read the Privacy Notice, visit generali.hu and click on Data Processing (Adatkezelés) at the bottom of the page.

Date: . . . . . .

. . . . . .
Signature of the insured, or of a close relative of the insured if the insured has died, or of the legal representative – parent, guardian, trustee – if the insured is a minor, or is a ward of state

Policy number: . . . . . Policyholder's name: . . . . . .

Please make sure you enclose the documents listed below with your service request!

You are kindly reminded that if the claimant fails to submit the documents required for the assessment of the claim, or if not all the required documents are submitted, the insurance company may refuse the claim or assess it on the basis of the documents available. Please note that the insurance company may ask you to present the original document(s).

After an accident

- ☐ a copy of the police report/workplace accident & injury report (expert opinion, hearing minutes, if one was made)
- ☐ a copy of the official on-site report of the passenger carrier company (if one was made)
- ☐ the result of the blood alcohol test (if administered)
- ☐ a copy of the documents produced during the first medical treatment

Additionally

In the event of death or accidental death

- ☐ a copy of the death certificate
- ☐ a copy of the cause of death medical certificate
- ☐ a copy of the autopsy report
- ☐ hospital course of the deceased
- ☐ a copy of all medical documents created in connection with the death
- ☐ if the insured dies abroad, an attested Hungarian translation of the certificate issued by the foreign authority about the circumstances of the death,
- ☐ a copy of a binding grant of probate or a certificate of inheritance (to be attached only if no beneficiary has been named earlier)
- ☐ the attending physician's statement*

In the event of permanent disablement as a result of an accident

- ☐ copies of all the medical documents produced from the time of the first treatment until filing the insurance claim (medical reports on treatments, examinations, hospital discharge summaries, etc.)
- ☐ the latest treating physician's statement describing the medical condition, in conformity with the prescribed form
- ☐ if a chronic condition deteriorates: copies of all the medical reports on treatments, examinations taken after the determination of the insurance benefit

In the event of permanent disablement (disability/loss of earning capacity

- ☐ if disability is established, copies of the documents submitted to and issued by the official body authorized to assess the extent of the impairment, as well as decisions, expert opinions (the disability certificate and the expert opinion are always required)
- ☐ the attending physician's statement*

In the event of critical illness

- ☐ a copy of the hospital discharge summary (NOT a medical certificate from the hospital)
- ☐ if the insured had a surgery: a copy of the description of the surgical procedure with indication of the surgical (WHO) code (please, check the surgery description as the insurance benefit can only be paid out on the basis of the WHO code)
- ☐ other medical documents specified in the Special Conditions of Critical Illness – Dread Disease – Insurance
- ☐ the attending physician's statement*

In any period of incapacity

- ☐ a copy of a qualified physician's written statements (sickness certificate) on the period of the sick leave, or in the absence thereof, a statement issued by the social insurance paying agent in support of the period of the sick leave
- ☐ if the insured was hospitalized: hospital discharge summary (NOT a medical certificate from the hospital)
- ☐ if the insured was treated in an outpatient clinic: outpatient records
- ☐ for continuous periods of incapacity, the documents produced by the treating physician every 60 days

In the event of involuntary loss of employment

- ☐ a copy of the (2-page) resolution issued by the regional employment center on the insured's receiving entitlement to job-seekers' benefit or allowance
- ☐ a certificate issued by the regional employment center confirming if the unemployment is ongoing must be presented monthly

For Fee-for-service Health Insurance

- ☐ the original invoice specifying the delivered health care service
- ☐ a copy of all medical documents related to the insured event (e.g.: outpatient records, hospital discharge summary, examination records, nursing and hospital care documentation, test findings, laboratory records, images made during diagnostic or histology tests, prescriptions, referrals, etc.) including all precedence medical documentation and the documents produced during the first medical treatment

☐ **Other:**

Number of attachments: . . . . . .

* A statement by the treating physician or general practitioner stating the primary disease(s) (indicating the BNO code) underlying the insurance claim and the exact date of the first diagnosis of the disease(s).

The fastest way to notify your insurance claim is making it online through generali.hu/Home/Online_ugyfelszolgalat/Karbejelentes/SzemelyBiztositas

Please make sure you deliver the completed insurance claim form together with the attachments to a customer service office of Generali Biztosító Zrt. closest to your home, or send it electronically to generali.hu@generali.com.

SZEMÉLYES LEADÁS ESETÉN TÖLTENDŐ KI (kivéve alkuszi átvételnél)!								Átvevő munkatárs aláírása	Szerződő/bejelentő aláírása
Nyomtatvány átvételének időpontja					Átvevő munkatárs neve	Tanácsadói kód vagy munkatársi azonosító	A munkatárs		
Év	Hónap	Nap	Óra	Perc					
							☐ belső munkatárs ☐ függő tanácsadó ☐ többes ügynök		