CLAIM NOTIFICATION

DUE TO:

- ◯ Serious illness of the insured
- ◯ Insured's death as a result of an accident

Policy/agreement No: _____

Insuringparty: _____

_____

Date of beginning of coverage: __ __ ____ Date of event: __ __ ____

INSURED:

Surname: _____ PESEL (Personal ID No): _____

Name: _____ Date of birth: __ __ ____

Telephone: _____ Mobile: _____

E-mail: _____

Address of residence:

Street: _____

Building No: _____ Apartment No: _____

Postal code: __-__ Post office: _____

City/Town: _____

Address for correspondence (if different than the address of residence):

Street: _____

Building No: _____ Apartment No: _____

Postal code: __-__ Post office: _____

City/Town: _____

BENEFICIARY (in the event of the Insured's death as a result of an accident):

Surname: _____ PESEL (Personal ID No): _____

Name: _____ Date of birth: __ __ ____

Telephone: _____ Mobile: _____

E-mail: _____

LUXMED UBEZPIECZENIA

luxmed.pl

LMG Försäkrings AB S.A. Branch in Poland
Szturmowa 2 Street, 02-678 Warsaw
t: 22 450 45 00, 22 450 50 10, f: 22 331 85 85

District Court for the Capital City of Warsaw in Warsaw
13th Commercial Division of the National Court Register
KRS: 0000395438

Tax ID No (NIP): 108 001 14 94, Statistical ID No (REGON): 145156729
Share capital: EURO 5,800,000.00

Address of residence:

Street: _____

Building No: _____ Apartment No: _____

Postal code: __-__ Post office: _____

City/Town: _____

Address for correspondence (if different than the address of residence):

Street: _____

Building No: _____ Apartment No: _____

Postal code: __-__ Post office: _____

City/Town: _____

INCIDENT DETAILS:

Illness onset date: _____ or accident date: __ __ ____

Has the Insured been previously diagnosed with the same or similar illness? ○ Yes ○ No

Type of accident: ○ Accident in the workplace ○ Communication accident ○ Accident at home

○ Other: _____

_____

_____

Was the Insured under the influence of alcohol at the time of accident? ○ Yes ○ No

Was the Insured under the influence of intoxicants at the time of accident? ○ Yes ○ No

Illness details or accident circumstances: _____

_____

Place of accident: _____

_____

Were the following notified about the accident:

The Police/Prosecutor's Office: ○ Yes ○ No

Unit name: _____

Street: _____

Building No: _____ Apartment No: _____

Postal code: __-__ Post office: _____

City/Town: _____

The Emergency Ambulance Service: ◯ Yes ◯ No

Unit name: _____

Street: _____

Building No: _____ Apartment No: _____

Postal code: __-__ Post office: _____

City/Town: _____

TREATMENT DETAILS:

Please provide the addresses of medical facilities used by the Insured after the illness occurrence::

1. _____ from _____ to _____

2. _____ from _____ to _____

3. _____ from _____ to _____

Is the treatment completed? ◯ Yes ◯ No

Expected date of treatment completion: __ __ ____

Surname and address of the physician treating the Insured, the general practitioner and address of the clinic at which the Insured is currently registered and had been previously registered, if a change took place within the last year.

_____

_____

BENEFIT PAYMENT FORM:

Bank transfer to the account:

Bank/Branch: _____

Account holder: _____

Account No: _____

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KRS: 0000395438

Tax ID No (NIP): 108 001 14 94, Statistical ID No (REGON): 145156729
Share capital: EURO 5,800,000.00

DECLARATION OF THE INSURED/BENEFICIARY:

- ○ I hereby confirm that all of the information provided above is complete and true, and I consent to its processing. I confirm I was informed that any withhold information or provide untrue information, LMG Försäkrings AB SA Branch in Poland shall not be held liable on the terms provided in the Civil Code provisions.
- ○ I hereby consent for processing my personal data concerning health by LMG Försäkrings AB SA Oddział w Polsce for the claim procedure in connection with my claim notification.

Date	City/town	Signature of the Insured/Beneficiary

The following original documents or certified copies shall be enclosed with this claim notification:

For claim notification due to serious illness:

Hospital discharge summary or certificate from a medical specialist (as per the definitions in the "Serious Illness List") confirming the final diagnosis of serious illness covered by insurance.

Histopathology results concerning the serious illness (as applicable).

For claim notification due to the Insured's death as a result of accident:

Insured's death certificate (official copy or certified copy). Certificate stating the cause of death (statistical death card or medical diagnosis). Accident protocol, if the insurance event is its consequence.

Results of an autopsy, if conducted.

Document confirming the acquisition of rights to the benefit if the entitled person has not been assigned as the Beneficiary.

The Insured should send the completed form with the documents to:

LUX MED Insurance, Departament Zarządzania Siecią
Szturmowa 2 Street, 02-678 Warsaw
or the following e-mail address: roszczenia.ubezpieczenia@luxmed.pl

Fair processing note, including in particular: data controller contact details, lawful ground for processing personal data and individual rights is enclosed to the insurance agreement.