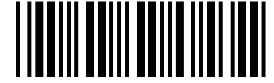
Kooperativa
VIENNA INSURANCE GROUP

Send the completed form, including attachments, to:
Kooperativa pojišťovna, a.s.,
Vienna Insurance Group
Centrum zákaznické podpory
centrální podatelna
Brněnská 634, 664 42 Modřice

Reception stamp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Claim notification based on medical expenses abroad

A. THE INSURER

Kooperativa pojišťovna, a.s., Vienna Insurance Group, Pobřežní 665/21,186 00 Praha 8, Czech Republic
Company No. (IČ) 47116617, incorporated in the Companies Register of the Municipal Court in Prague, File No. B 1897

B. THE INSURED

Personal ID number[1]	Surname	First name	Title	Citizenship other than the CZ - specify[2])

Permanent residence/ residence address	Street (municipality), building (cadastre) number/street number	Post Code
Municipality – post office	State other than the CZ - ZIP code[2])	
E-mail	Mobile number	Telephone number
Mailing address[3])	Street address, building (cadastre) number/street number	Post Code
Municipality – post office		

Account owner/ cardholder[4])	Personal ID number	Surname	First name	Title

[1]) With foreign nationals, write the date of birth in the RRMMDD/9999 format.
[2]) If left blank, it is understood as the Czech Republic.
[3]) To be completed if different from the permanent residence/registered office address of the policyholder.
[4]) When reporting a claim involving a family member under travel insurance with a ČS account or payment card, please specify the particulars of the account owner or cardholder for whom the ČS cover is arranged.

C. COVER AND CLAIM PARTICULARS

Insurance policy number	Insurance start date	Duration of stay abroad: from / to

Are sports activities covered? ☐ Yes ☐ No
Was an assistance provider contacted? ☐ Yes ☐ No
Date the assistance provider was contacted

Name or code of the insured's health insurance company

Date of policy event (loss)

Place of medical treatment

State

For an accident caused by a third party, state their name and address

Describe the cause and circumstances of the claim in detail (the disease or injury, or cause of death in the event of death)

Name and address of the GP or specialist (surgeon, internist, neurologist, etc.) in the CZ

Had you suffered from the disease for which you sought medical treatment abroad before the commencement of your insurance cover? ☐ Yes ☐ No

If so, for how long?

Did you apply for compensation of costs under Section 14 of Act No. 48/1997 on public health insurance, as amended, with your health insurance company? If so, ask your health insurance company to complete section F of this form. If not, complete section E of this form. ☐ Yes ☐ No

Do you have the same type of cover with another insurer? ☐ Yes ☐ No

If so, which one? State the insurance policy number and its validity. From - to

Amount of expenses paid in cash

For medical treatment	For medications and devices	Other costs

D. SETTLEMENT PAYMENT METHOD

Remit the claim settlement to (choose just one of the options)

☐ Account number | Bank code | Specific symbol

☐ Permanent residence/residence address given in section B

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E. POWER OF ATTORNEY

I, (first name and surname), **the Insured,**

hereby authorise Kooperativa pojišťovna, a.s., Vienna Insurance Group, Company No. 47116617, with a registered office at Pobřežní 665/21, Praha 8, to represent me in all legal actions associated with raising my claim towards

(name and registered office of health insurance company)

for payment of the amount, I am entitled to under Section 14 of Act No. 48/1997 on public health insurance, as amended, in connection with my necessary and urgent treatment, the need for which arose during my stay abroad

from **to** **and for the acceptance of such compensation.**

Date 2 0 2

Signature of the Insured (authorised person)

Signature of statutory representative if the Insured (authorised person) is legally incapable

F. HEALTH INSURANCE COMPANY CERTIFICATE

Health insurer code

The health insurance company (name, registered office):

hereby confirms that, under Section 14 of Act No. 48/1997 on public health insurance, as amended, it has paid the Insured named on the front page

of this form an amount of .... **CZK for medical expenses abroad on the basis of the presented receipts**

in the amount of .... **(give the amount in the relevant foreign currency).**

Date 2 0 2

Health insurer stamp and signature

G. INFORMATION ON THE PROCESSING OF PERSONAL DATA

PROCESSING OF PERSONAL DATA
The following section contains important information on the processing of your personal data. Further information, including the option of objecting to processing based on a legitimate interest, the right of access, and other rights, can be found in the document entitled "Information on Processing Personal Data in Casualty Insurance". This can be accessed at www.koop.cz, in the section "About Kooperativa".

Information on processing data about health
It is important to note that, where health **information** is necessary for a claim investigation, the insurer processes it as necessary to **determine, exercise, and defend legal titles** for the purposes of insurance policy management and termination, claim settlement, and defence from unauthorised or illegal claims, and the prevention and investigation of fraud, reinsurance, and joint insurance.

Information on personal data processing other than health information
It is important to note that the insurer processes identification and contact data, data for risk valuation when entering into insurance, and data of service utilisation based on their **legitimate interest** for the purposes of proper setting and observance of contractual relationships with the policyholder and associated relationships with the insured and/or damaged party, management and termination of an insurance policy, claim settlement, reinsurance and joint insurance, protection of the insurer's rights, and prevention and identification of insurance fraud and other illegal acts. You have the right to file an objection to such processing at any time, provided this is submitted in the manner specified in the Information on Processing Personal Data in Personal Insurance.

It is important to note that the insurer also processes the aforementioned personal data on the basis and for the purpose of observing statutory obligations applicable to insurers.

By submitting this form, you confirm that you have thoroughly familiarised yourself with the document entitled "Information on Processing Personal Data in Casualty Insurance", including but not limited to the scope of the data processed, legal basis (reasons), purposes, and time of processing personal data (and the rights you have in this respect).

I confirm that I have provided all the information in this form fully and truthfully. I am aware of the legal consequences of providing incomplete or untrue information to facilitate the insurer's obligation to settle claims.

Date 2 0 2

Signature of the Insured (authorised person)

Signature of statutory representative if the Insured (authorised person) is legally incapable

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