IMEDI
Health Insurance

Form of a claim Annex No. 8

Data of the insured consumer:

Name, surname ______________________

Day/month/year of birth ______________ Personal ID ______________

email ______________ Contact number ______________

Number of the Insurance Policy ______________ Insurance Period from ______ to ______

Insurance/project ☐ corporate

other ______________

Name of the organization, the consumer is insured from ______________

The applying consumer and the insured consumer are one and the same individual ☐

Data of applying consumer:

Name, surname/name of the organization ______________ Personal ID ______________

Contract number ______________ email ______________

Contact with the insured consumer ______________

☐ letter of guarantee ☐ indemnification other ______________

Type of represented/provided medical service ☐ ambulatory ☐ medicines other ______________
☐ stomatology ☐ hospitalization ______________

Has your Insurance Event/claim been reviewed? ☐ yes ☐ no

Please, formulate your request ______________

Please mark only one option of receiving an answer:	☐ Receive via e-mail; ☐ Receive in company's service-center.
Please mark only one option of receiving an answer in case if your demand is supplied:	☐ I agree to receive an answer via phone call; ☐ I agree to receive an answer via e-mail; ☐ I agree to receive an answer in company's service-center.

Signature of the insured/applying consumer ______________ Date ______________

The application shall be reviewed within 30 calendar days upon submission all necessary documentation.

Thank you for insuring with us