FOREIGNERS' HEALTH INSURANCE INDEMNITY APPLICATION

Application No.: _____

Policyholder or Beneficiary

Name, Surname/Name of the Company: _____

Identity number/Date of birth/Registration No.: _____

Residence address in Latvia: _____ LV - _____

Phone number: _____ e-mail address: _____

Insured person

Name, Surname: _____

Identity number/Date of birth: _____

Residence address in Latvia: _____ LV - _____

Permanent residence address: _____

Phone number: _____ e-mail address: _____

Insurance contract

Insurance policy number: _____ Insurance period from: _____ to: _____

Event

Date of event: _____ Place of event: _____

Losses incurred: ☐ Medical expenses ☐ Transportation expenses ☐ Repatriation expenses

Description of the event: _____

_____

_____

_____

_____

Sum of expenses EUR: _____ Deductible EUR: _____

Beneficiary's bank details

Name of a bank: _____

SWIFT code: _____ IBAN: _____

Enclosed documents

☐ Copy of passport ☐ Copy of residence permit ☐ Extract from medical card ☐ Copy of receipts, invoices ☐ Copy of death certificate

☐ Other: _____

By signing this Indemnity application, I confirm that the information provided above is correct. I am aware that by providing false or misleading information, If P&C Insurance AS Latvijas filiāle has the right to refuse to pay insurance indemnity to me or to the person specified in the insurance contract and that I may be held responsible in accordance with the procedures prescribed in the regulatory enactments of the Republic of Latvia.
With my signature, I confirm that in accordance with the Personal Data Protection Law and other regulatory enactments, I permit (or in case if the Beneficiary specified in the insurance policy, the Insured person and person that signs the insurance indemnity application is not the same person as the person who has signed this insurance indemnity application I confirm that I have received and, if necessary, will present the relevant written permission) If P&C Insurance AS Latvijas filiāle as the system administrator and data operator to process my, the Insured person or the Beneficiary specified in the insurance contract data to ensure the implementation of the insurance policy and for the purposes of market research and offering insurance services. The data shall include, but not be restricted to, sensitive personal data. I further permit If P&C Insurance AS Latvijas filiāle to receive my, the Insured person's or Beneficiary specified in the insurance policy data from State and local government institutions, private individuals and/or legal entities.
By this, I confirm that copies of the attached documents are made from and fully correspond to the original documents. I undertake to keep originals of the attached documents for at least three years and to present them upon request of If P&C Insurance AS Latvijas filiāle with no delay, but no later than within five working days.

Name, Surname: _____, Applicant's signature: _____

Date: _____

If P&C Insurance AS Latvijas filiāle
Reģ. Nr. 40103201449

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