DZI - General Insurance
Republic of Bulgaria
1463 Sofia, № 89B Vitosha Blvd.
e-mail: clients@dzi.bg

**24/7 Contact Center 0700 16 166**
**www.dzi.bg**

**Form LZ 53 G**

# C L A I M

for payment of amounts to individuals
**Accident insurance**
under insurance policy № ……

## 1. Entitled person *

Name ……., PIN/PFN …….. place of work:……
*(three names of the entitled person)*
Personal ID card/ Passport № ……., issued by ……..... on date ……..……...
Permanent address (including country):…….. post code ……..……..
Address for correspondence (including country):…….. post code ……..……..
Mobile phone:……..…….. e-mail: ……..……
***I agree to receive all correspondence on the claim through the e-mail address indicated by me, including for required documents and statements:*** **yes** □ **no** □
Legal representative / Authorized person …… PIN/PFN ……

## 2. Claim risk

| | | |
|---|---|---|
| ☐ Temporary total disability due to accident | ☐ Permanent total disability due to accident | ☐ Death due to accident |
| ☐ Broken bones and burns | ☐ Surgery | ☐ Hospital daily cash benefit due to accident |
| ☐ Medical expensis | ☐ Other …… | |

## 3. The amounts is to be transferred to bank account:

IBAN | | | | | | | | | | | | | | | | | | | | |

IBAN | | | | | | | | | | | | | | | | | | | | |

BIC | | | | | | | | |

BIC | | | | | | | | |

I have been informed by the Insurer that if the holder of the bank account I provide is another person, it is also necessary to submit an explicit written power of attorney with a notary certification of the signatures, which contains a statement that I have the right to receive the payment in person.

## 4. Information about the insurance event

Date of claim: Place of claim:

Type of accident: □ occupational accident □ accident

Brief description of the event: ……
……
……
……

| | |
|---|---|
| Where the treatment was performed? *(Name of doctor/ hospital, address and telephone)* | |
| General practitioner: *(Name, address and telephone)* | |
| Do you have previous illnesses, accidents or other disabilities? *(If yes, please list and attach documents)* | |

## 5. Attached documents (please mark with X or another symbol):

| | | |
|---|---|---|
| ☒ Certificate for personal bank account; | ☐ Expert decision of TEMC / NEMC; | ☐ Death notice; |
| ☐ Certificate from employer / school; | ☐ Declaration of occupational accident; | ☐ Death certificate; |
| ☐ Sick leave _ number; | ☐ Order of the National Social Security Institute; | ☐ Certificate of heirs; |
| ☐ Ambulatory list _ number; | ☐ Protocol for investigation of the occupational accident; | ☐ Car accident report; |
| ☐ Epicrisys _ number; | ☐ Invoice with receipt _ number; | ☐ …… |

* ***Note:*** *In case of occurrence of some events and if the entitled persons are more than one, this claim form is filled in separately by each of the entitled persons.*

## 6. Information and declarations:

By signing, I declare that:

1. I understand the content and the meaning of the questions in this Claim form. I declare that my answers are correct, comprehensive and provided in good faith.
2. I have been informed that the Insurer under the contract is DZI-Life Insurance JSC, UIC 121518328, with registered office and address of management: 1463 Sofia, 89B Bulgaria Blvd., 24/7 contact center 0700 16 666, e-mail: clients@dzi.bg and website: www.dzi.bg.
3. I have read the General terms and Conditions of the insurance contract.
4. I have received, I am acquainted with and accept the „Personal Data Protection Information" prepared by the Insurer in its capacity of a personal data controller, in compliance with the requirements of Article 13 and Article 14 of Regulation (EU) 2016/679 (General Data Protection Regulation). I am informed that the „Personal Data Protection Information" is also published on the website of the Insurer - www.dzi.bg I voluntarily provide personal data of the Insured/Entitled Person for the purpose of performance of Insurer's obligations under the concluded the insurance contract. I process lawfully the personal data of the Insured/Entitled Person, provided to the Insurer for the purpose of settlement of insurance claims, in compliance with the statutory requirements under Regulation (EU) 2016/679 and the Personal Data Protection Act.
5. I have been informed that in connection with the claim, I have the right to file complaints for claim payment in each territorial division of the Insurer (Central Office, main agency, agency, office) in writing. The rules of DZI-Life Insurance JSC for claims settlement under Art. 104, para 1 of the insurance Code are published on the company's website: www.dzi.bg, in the section "Assistance in case of a claim".
Complaints against the Insurer may also be submitted ti the Financial Supervision Commission – 1000 Sofia, 16 Budapeshta Str., or by e-mail: delovodstvo@fsc.bg; Consumer Protection Commission – 1000 Sofia, 4A Slaveykov Square or on the website www.kzp.bg and the Personal Data Protection Commission – 1592 Sofia, 2 Prof. Tsvetan Lazarov or by e-mail: kzld@cpdp.bg, as well as to other competent authorities. All disputes on which no agreement has been reached between the parties may be referred for resolution by the relevant Bulgarian court, in the general order or considered out of court in proceedings on Alternative Dispute Resolution before the Sectoral Conciliation Commission of the Consumer Protection Commission or through mediation.
6. I have received a copy of the filed claim and I am familiar with the documents required for payment of amounts.

I am informed that pursuant to Article 108, paragraph 1, item 2 of the Insurance Code, in the event of failure to submit the explicitly requested documents, the Insurer will deliver its claim statement within 6 /six/ months from the date of its filing, and in case of lack of evidence of the insured event and/or damages, the Insurer will refuse payment.

Date:…….. Signature of the entitled person:…….

The section below is to be completed by a DZI employee who has accepted the claim:

Claim number in the register of payments №……..…..... /……...……
Telephone number for information for the claim: ……....….....
The data of the person submitting the claim have been verified by a valid identity document.
Employee of DZI-Life Insurance JSC ……....

List of missing documents required to process the claim:
1. ……..……..……
2. ……..……..……
Prepared by a DZI employee: .....……

| Additional submitted document: | On date: | DZI employee | Signature |
|---|---|---|---|
| | | | |
| | | | |