

CLAIM

for payment of amounts to individuals
 for the risks **Permanent Disability, Temporary Disability,
 Especially serious diseases and Death**
 under **Life and Risk Life** insurance contracts
 for insurance policy №

1. Entitled person *		
Name, PIN/PFN place of work:..... <i>(three names of the entitled person)</i>		
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 <input type="checkbox"/> no <input type="checkbox"/>		
Legal representative / Authorized person		PIN/PFN
2. Claim risk:		
<input type="checkbox"/> Temporary total disability due to accident	<input type="checkbox"/> Permanent total disability due to accident	<input type="checkbox"/> Especially serious diseases
<input type="checkbox"/> Temporary total disability due to sickness	<input type="checkbox"/> Permanent total disability due to sickness	<input type="checkbox"/> Death under risk Life insurance
<input type="checkbox"/> Other		
3. The amounts is to be transferred to bank account:		
IBAN	<input style="width: 100%;" type="text"/>	IBAN
BIC	<input style="width: 100%;" type="text"/>	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:
Brief description of the event:		
Where the treatment was performed? <i>(Name of doctor/ hospital, address and telephone)</i>		
General practitioner: <i>(Name, address and telephone)</i>		
Do you have previous illnesses, accidents or other disabilities? <i>(If yes, please list and attach documents)</i>		
5. Attached documents (please mark with X or another symbol):		
<input checked="" type="checkbox"/> Copy of identity document;	<input type="checkbox"/> Sick leave _ number;	<input type="checkbox"/> Death notice;
<input checked="" type="checkbox"/> Certificate for personal bank account;	<input type="checkbox"/> Ambulatory list _ number;	<input type="checkbox"/> Death certificate;
<input type="checkbox"/> Insurance policy	<input type="checkbox"/> Epicrisys _ number;	<input type="checkbox"/> Certificate of heirs;
<input type="checkbox"/> Expert decision of TEMC / NEMC;	<input type="checkbox"/> Car accident report;	<input type="checkbox"/>
<input type="checkbox"/> Certificate from employer;	<input type="checkbox"/>	<input type="checkbox"/>
6. Declaration based on Art. 42, para. 2, item 2 of The Anti-Money Laundering Measures Act:		
Do you fall into the category of a politically exposed person (PEP) or a person related to PEP within the meaning of Art. 36 of the AML Act? yes <input type="checkbox"/> no <input type="checkbox"/>		
If yes, please fill in a separate declaration form		

* **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.

7. 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