



## Travel insurance medical claim

Fill out the ENTIRE claim in legible capital letters.

### Data about the person insured

Name and surname: \_\_\_\_\_ Date of birth:   .   .

Permanent address: \_\_\_\_\_

Contact tel. no.: \_\_\_\_\_ E-mail address: \_\_\_\_\_

### Data about the person insured (if other than the person insured)

Name and surname: \_\_\_\_\_ Date of birth:   .   .

Permanent address: \_\_\_\_\_

Contact tel. no.: \_\_\_\_\_ E-mail address: \_\_\_\_\_

### Insurance benefit payment

To the service provider  To transaction account

Name and surname of the account holder\*: \_\_\_\_\_ Bank name and address: \_\_\_\_\_

Account number: \_\_\_\_\_ BIC / SWIFT (mandatory for transfers abroad): \_\_\_\_\_

\*if the account holder is a third party, fill out the Statement on assignment of insurance benefit

### Statement on assignment of insurance benefit

The undersigned: \_\_\_\_\_

assign the insurance benefit to which I am entitled under the concluded insurance contract to the benefit of:

Name and surname: \_\_\_\_\_ Date of birth:   .   .

Permanent address: \_\_\_\_\_ Citizen ID no.: \_\_\_\_\_

and declare that I shall not claim insurance benefit from Vzajemna zdravstvena zavarovalnica, d.v.z.

\_\_\_\_\_  
Place and date

\_\_\_\_\_  
Signature of the person insured and/or their legal representative

### Data about the insurance case

Policy number: \_\_\_\_\_

Date of the event:   .   .     Country: \_\_\_\_\_ Date of departure to foreign country\*:   .   .

Date of arrival to home country:   .   .

\*State the last date of departure to foreign country before the occurrence of the insurance case. Submit evidence (e.g. a copy of flight ticket, etc.)

Purpose of travel (business, private, treatment abroad, etc.): \_\_\_\_\_

In case of business travel, state the function performed (attach a copy of the travel order): \_\_\_\_\_

Contact with assistance partner?  YES  NO Date of call:   .   .

Contact with Vzajemna?  YES  NO Date of call:   .   .

If contact has not been established, please state the reason: \_\_\_\_\_

Was emergency medical service provided?  YES  NO

Did you have to immediately return to Slovenia/home country due to your medical condition?  YES  NO

Have you been treated for the consequences of this disease/injury prior to departure to foreign country?  YES  NO

Did you suffer from any other diseases/injuries before travel?  YES  NO

Which? \_\_\_\_\_

Provide a detailed description of the circumstances and state the relevant data about the insurance case (what were the symptoms and how did the disease/injury occur, which services were provided, etc.):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Diagnosis: \_\_\_\_\_



### Insurance claim

Description of the cost (purchase of medicine, doctor examination, etc.)	Provider (e.g. Chicago Medical Hospital)	Amount charged and currency (e.g. 350 USD)	Did you yourself pay the invoice?
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
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			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO

**Direct marketing consent** (not signing/selecting the statement below shall not mean that you have revoked any consents given previously)  
By signing/selecting this statement, I give Vzajemna consent, until revocation, for the processing of my personal data, which Vzajemna processes based on the concluded insurance contracts, including data provided on the form intended to ascertain needs and requirements, or by my joining the Varuh zdravja loyalty programme, participation in prize-winning competitions and events (co-organised by Vzajemna (runs, marathons and other events), my usage of Vzajemna's online services, or my other business interactions with Vzajemna, excluding data on my health status, for the purpose of direct marketing, which includes customised offerings based on the evaluation and anticipation of my interests, economic status, needs, etc. via ordinary mail and e-mail, SMS, MMS and telephone. I am aware that I have the option to revoke my consent at any time. I can do so by sending a written statement to Vzajemna zdravstvena zavarovalnica, d.v.z., Vošnjakova ulica 2, SI-1000 Ljubljana, or getting in touch at info@vzajemna.si or over the telephone at 080-20-60. Vzajemna will cease the processing based on the revoked consent no later than within 15 days after receiving said revocation.

### Statement

The person insured or their legal representative hereby declares to have reported all circumstances related to the insurance case, to have submitted all the invoices and all the documentation related to the insurance case and that all the data stated and documentation submitted are accurate and complete. I hereby authorise the insurance company to inspect my medical documentation in order to check if this claim is justified. If the insurance company finds the data to be false or the data and documentation related to the insurance case to be incomplete, it may reject the claim. The person insured also declares that will not claim reimbursement for this insurance case from another insurance company and understands that giving false information is a criminal offense. The person insured or their legal representative hereby authorises the insurance company to file, in my name and for own account, a recourse claim up to the amount of the insurance benefit paid under this claim against a third party who is responsible for the occurrence of the insurance case or obligated to reimburse the costs of services rendered due to the occurrence of the insurance case. The person insured or their legal representative hereby authorises the insurance company to file a claim, in my name and for own account, up to the amount of the insurance benefit paid under this claim, for reimbursement of the costs of medical services that are reimbursable from compulsory health insurance under the application regulations of the Republic of Slovenia.

Place and date

Signature of the person insured or their legal representative

Signature of the claimant

## IMPORTANT - before filing the claim please check that:

- The claim form has been completely filled out
- The claim has attached all invoices, prescriptions and medical documentation (slips are unacceptable)
- You notified us in the claim of any change to your personal data during the insurance term
- A separate claim form has been filled out for every event
- If the loss was suffered by a person under age, the claim was filled out by the legal representative of the person insured

We recommend that you keep copies of all the documentation submitted. Vzajemna, d.v.z. shall not be responsible for documentation not received for any reason beyond its control.

The claim is to be send to the following address:

**Vzajemna, d.v.z.**  
**Insurance Case Department**  
**Vošnjakova ulica 2**  
**1000 Ljubljana**  
or by e-mail to [vzajemna-skode@vzajemna.si](mailto:vzajemna-skode@vzajemna.si)

For any questions, call the Contact Centre at the toll free number: 080 20 60 or write to the e-mail address: [vzajemna-skode@vzajemna.si](mailto:vzajemna-skode@vzajemna.si)

### To be filled out by Vzajemna, d.v.z.

Claim report number: \_\_\_\_\_ Received on: \_\_\_\_\_ Policy number: \_\_\_\_\_

Insurance: \_\_\_\_\_ Form received by: \_\_\_\_\_ Notes: \_\_\_\_\_

Signature: \_\_\_\_\_