For Bulgaria Insurance only

Claim handler

Supervisor

Medical adviser

Manager

Final decision

Comments on payment

Insured by

BULGARIA Insurance

Bulgaria Insurance AD
83A Bulgaria Blvd.,
1404 Sofia, Bulgaria.
Tel: +359 (0) 700 13 555
www.bulgariainsurance.bg
Authorised by the
Financial Supervision Commission,
License № 432-03/14.06.2013

Re-insured by

AXA PPP healthcare Limited.
Registered office: 5 Old Broad Street, London, EC2N 1AD, United Kingdom.
Registered in England No. 3148119.
Authorised by the
Prudential Regulation Authority and regulated by the
Financial Conduct Authority
and the Prudential Regulation Authority.

PB65718

Insured by

BULGARIA Insurance

Re-insured by

Claim Form

Bulgaria Insurance

HEALTH WITHOUT BORDERS

International Healthcare Plans

Please complete all sections using CAPITALS and blue ink. You must fully complete sections 1, 2, 3 and 4. Your medical practitioner must complete sections 6, 7, and 8 in full. Both you and your medical practitioner must sign and date this form and it must be accompanied by original receipted and numbered invoices, and prescriptions or it may not be processed. You must provide your Personal No. in order for us to process your claim.

If you have any questions regarding this form or any other aspects of your cover, please telephone on:
Tel: +359 (0) 700 13 555 and ask for the Health Insurance Department.

1. Subscriber and patient details

Subscriber's name | *PIN (Personal Identification Number)*

Patient's name | *PIN (Personal Identification Number)* | *Membership number from your card*

Patient's address | *Group number (if applicable)*

Patient's date of birth (if different)

Telephone No. | *Mobile No.* | *Daytime phone number*

E-mail | *Patient's relationship to member*

2. To be completed by Patient *(or Parent/Guardian if Patient is under 18 years of age)*

1. If payment is to be made to someone other than the subscriber (eg. the Patient's guardian) please complete the following:

I authorise benefit to be paid directly to

Title | *Name*

Address

Signature of subscriber/guardian:

Date:

2. Payments will be made in BGN unless we agree otherwise in writing.

In which currency was the treatment originally billed?

Name and telephone number of Patient's family doctor

IBAN:

BIC:

Name of account holder:

3. If treatment was received outside Bulgaria, you must answer the following questions:

(a) Country where treatment took place

(b) The reason for the patient being abroad

(c) Dates of departure and return to Bulgaria from _____ *to* _____

4. Are you claiming cash benefit for in-patient treatment? Please tick ✓ ☐ Yes ☐ No
If yes, please enclose a copy of the admission and discharge forms from the hospital or clinic.

3. Other insurer's details

Is the treatment accident-related? Please tick ✓ ☐ Yes ☐ No *Is it covered under another insurance policy? Please tick* ✓ ☐ Yes ☐ No
If you have answered 'Yes' to either of these questions, please give the name, address and contact telephone number of the insurance company involved.

4. Patient's Declaration and Consent *(to be completed by parent/guardian or adult member if Patient is under 18 years of age)*

PERSONAL DATA PROTECTION

Bulgaria Insurance is committed to maintaining the privacy of personal data obtained in the course of its business activities and complying with applicable laws and regulations (e.g. EU General Data protection Regulation - GDPR) regarding the processing of Personal and Sensitive Personal Data. We recognize our responsibilities in relation to the collection, holding, processing, use and/or transfer of personal data under the Regulations in relation to Personal Data Protection.

We would like to inform you that by virtue of the above laws and regulations the personal data which you shall provide to us by completing this form, concerning you and any members of your family who are covered by the Bulgaria Insurance International Healthcare Plan, are being collected by Bulgaria Insurance in accordance with the purposes mentioned in the declaration which you have signed when you applied for the Bulgaria Insurance International Healthcare Plan. Specifically, the collection of the aforementioned data under this form is done for the purposes of:

1. Deterring any illegal claim and/or fraud or the same person claiming compensation twice from two different insurance companies.
2. Collecting evidence (verified and numbered invoices and prescriptions) for the purpose of processing the claim. Bulgaria Insurance may not be in a position to settle a claim if it lacks adequate information relating to the claimant and does not have the claimant's signature.
3. Correct internal administration and operation of Bulgaria Insurance as well as confirmation of cover. Bulgaria Insurance may not be in a position to settle a claim if it lacks knowledge as to who is the claimant, where the treatment was administered, and what treatment was given.
4. Confirmation as to whether the illness, accident, hospitalization etc. for which the claim is submitted is covered by the Bulgaria Insurance International Healthcare Plan.

All your data shall be kept confidential and shall not be disclosed to third parties unless required by Law. They shall be processed only by Bulgaria Insurance's authorised personnel who possess the appropriate professional and technical knowledge. You have the right of access to and rectification of the personal data that you submit to us.

Detailed information on the terms and conditions under which you can exercise your rights with respect to your personal data can be found in Bulgaria Insurance's Policy for exercising the rights of data subjects on our website (www.bulgariainsurance.bg), as well as in our offices.

Patient's declaration and consent

I declare that I am the Patient, parent or guardian of the Patient (if the Patient is under 18 years of age).

I have been informed that the personal data I provide (including that of the other persons insured) are processed by Bulgaria Insurance AD, in its capacity of a personal data controller, under the current legislation. I have read and agree to (as well as the other persons insured) the Privacy Notice under Art. 13 and Art. 14 of Regulation (EC) 2016/679, published on the Company's website: www.bulgariainsurance.bg and available in its offices.

I consent and authorise my doctor to discuss my illness and the details of my treatment with Bulgaria Insurance.
I agree that one copy of this consent document will have the validity of an original.

To be signed by the person concerned (parent/guardian if under 18)

Signature: ✗ _____ *Name:* ✗ _____ *Date:* ✗ _____

Send this claim form together with supporting material to:
Bulgaria Insurance, 83A Bulgaria Blvd., 1404 Sofia, Bulgaria.

5. Direct Settlement by Bulgaria Insurance

In-patient treatment must be pre-authorised by Bulgaria Insurance (see your handbook for details).
You must contact us on +359 (0) 700 13 555 at least 10 days before treatment to arrange this.

The claim form must be submitted within 90 days of the start date of the treatment along with all original and numbered receipts/invoices – as per the policy membership agreement. Claims will not be considered if not submitted within 90 days of treatment being received. The issue of this form does not imply any liability on the part of Bulgaria Insurance and/or AXA PPP healthcare Limited. We recommend you photocopy the completed form and any enclosures for your own records.

6. Medical Section

(To be fully completed by Patient's Medical Practioner – Please complete all sections using CAPITALS and blue ink. We will require evidence of any diagnostic tests undertaken and we may require the results of those tests. We will ask you if we do.) Please continue any questions on a separate sheet if necessary, marking clearly which question you are referring to. Please sign the sheet and attach it to this form.

1. Please give details of the symptoms presented:

_____

_____

2. Please give the date on which the Patient first became aware of any signs or symptoms of the conditions being claimed for (day, month & year):

_____

_____

3. Please give the date on which your Patient first consulted any Medical Practitioner for this condition: _____

4. Please give a full history of the medical condition requiring treatment including full details of any previous investigation/treatment together with relevant dates: *Dates:*

_____ _____

_____ _____

_____ _____

5. Was the patient referred to you by another medical practitioner?

_____

_____

***6.** Have you referred the Patient for any diagnostic procedures? If so please give details:*

_____

_____

_____

***7.** Please give the exact diagnosis (after all diagnostics have been completed):*

_____

_____

***8.** Please give details of any current and/or further treatment planned:*

_____

_____

_____

***9.** Drugs/other items prescribed (please list):* *Number of tablets/volume of liquid prescribed:* *Period covered by medication:*

_____ _____ _____

_____ _____ _____

_____ _____ _____

***10.** Name of Patient receiving treatment (please print):*

_____

7. Hospital or clinic information (To be completed by Medical Practitioner)

Hospital or Clinic name and address:

_____

Admission/treatment date: *Surgery date (if any):* *Anticipated discharge date:*

_____ _____ _____

8. Medical Practitioner declaration

I declare that I am the Patient's Medical Practitioner, and that the particulars given are, to the best of my knowledge, true and correct.

- How long has the patient been known to you? _____
- Do you have access to the patient's medical history? _____

Name of Medical Practitioner (please print): _____

Specialty: _____ *Hospital/Practice stamp:*

Signature: _____

Date: _____