MetLife

CLAIMANT'S STATEMENT NOTIFICATION OF ACCIDENT OR ILLNESS

1a

MetLife Europe d.a.c.
Irská společnost s reg. č. 415123
20 on Hatch, Lower Hatch Street, Dublin 2, Irsko
MetLife Europe d.a.c., pobočka pro Českou republiku
Purkyňova 2121/3, 110 00 Praha 1, IČ: 03926206
Zapsaná v OR vedeném MS v Praze | sp. zn. A77032
tel. 227 111 000 | info@metlife.cz | www.metlife.cz

Please complete the form by hand (not in black ink) or electronically

Identification data of the Insured

Policy number

First name and surname of the policy holder/insurance-premium payer – if different from the Insured

First name and surname of the Insured

Date of birth

Telephone

E-mail

Residential address

Postal code

Employer's name and address

Position

Insurance report

Date of the accident/first symptoms of the illness

Time

Place of the accident

Date of first medical examination

Time

Name of the physician and address of the healthcare facility where you were treated at first:

Please describe circumstances of your accident. In case of illness, please describe development of the illness:

Injury witness

Hospitalization from

to

Where

Period of inability to work from

to

Confirmation of inability to work issued by (name of the physician) and date of issue:

In case of extension of usual treatment period, please state reasons (describe complications):

Was the accident investigated by the police? If so, please provide address of the department and reference number: ☐ yes ☐ no

Was the injured part of body impaired prior to the current injury? Did you have the same or similar illness in the past? ☐ yes ☐ no

If so, please provide description and the date of previous injury or illness:

Please complete the following page.

If you were officially recognized to be disabled of third degree, please provide the date of origin of such disability and the reason (basic diagnosis pursuant to the SSA Disability Assessment): ☐ yes ☐ no

Name and address of your general practitioner, telephone contact, e-mail:

Names and address of physicians-specialists who examined you in connection with the current injury or illness (telephone contact, e-mail):

Have you concluded a life, accident or travel insurance policy with another insurance company as well? ☐ yes ☐ no

If so, please provide name of the insurance company, type of insurance and coverage amount:

Statement

I, the undersigned, file a claim for insurance benefit based on insurance policy mentioned above and declare that all information provided in this form is complete and accurate.

I hereby authorise all physicians, healthcare facility and other person/entity possessing information about my person and my health to provide the insurer or the insurer's representative with information related to illnesses, injuries, hospitalizations in healthcare facilities, consultations, inability to work, medical or diagnostic interventions or treatments. I agree that a copy of this statement has the same validity as the original. If I have not done so when concluding my insurance policy, I hereby grand to MetLife my consent to process my personal data concerning my health in terms of the Civil Code. I acknowledge that in terms of General Data Protection Regulation MetLife is entitled to process the data concerning my health even without my consent, because it is necessary for determination of the scope of legal claims. The Announcement concerning the data protection is available at the insurance intermediary or on the web pages of MetLife.

Signature of the Insured
(Signature of the legal representative in case of a minor child)

Signed in

Date ☐☐.☐☐.20☐☐

Supplemental information

Instructions for the Claimant

Please answer in full all questions in this form (1a).

Please submit the second form (1b) to your attending physician for completion.

Please attach to the completed form:
- copy of the medical report about treatment immediately after the injury or first symptoms of the illness
- copy of the medical report with a description of performed intervention
- copy of the hospital discharge report (for every hospitalization)
- copy of the police report related to the accident investigation
- if you file a claim for a benefit due to inability to work, also provide a copy of medical confirmation of inability to work, a copy of medical records (from follow-up examinations), a document confirming the amount of gross income for the last three months or, in case of self-employed person, a copy of the last tax declaration prior to occurrence of the insurance event, a document on payment of the insurance premium for sickness insurance in the case of a self-employed person for the period of three months preceding the start of inability to work and for the entire duration of inability to work, copy of claimant's trade certificate
- if you file a claim for waiver of premium, provide a copy of the SSA decision on granting of a third-degree disability pension and a copy of the Disability Assessment document.

Please send completed form and documents mentioned above to the address: MetLife pojišťovna a.s., Purkyňova 2121/3, 110 00 Praha 1.