Generali Osiguranje Srbija a.d.o.
Vladimira Popovića 8
11070 Beograd / Srbija
T +381.11.222.0.555
F +381.11.222.39.34

generali.rs

Zahtev za prijavu štete dobrovoljnog zdravstvenog osiguranja
Voluntary Health Insurance Claim Form

Ovaj formular se koristi kada osigurano lice koristi medicinske usluge u Mreži pružalaca zdravstvenih usluga sa kojom Generali Osiguranje Srbija a.d.o. ima važeći ugovor o pružanju usluga. Zahtev za isplatu naknade pružalac zdravstvenih usluga iz Mreže pružalaca zdravstvenih usluga dostavlja Generali Osiguranju Srbija a.d.o. na adresu navedenu u donjem delu formulara. Uz zahtev se prilažu originalni račun (specifikacija troškova), nalazi lekara i druga prateća originalna dokumentacija.

This form is used when the insured person uses medical services provided within the healthcare service providers Network with which Generali Osiguranje Srbija a.d.o. has a valid service contract. Request for reimbursement is to be submitted by a service provider – member of the healthcare service providers Network, to Generali Osiguranje Srbija a.d.o., to the address at the end of the form. Original receipt (list of expenses), doctor's reports and other additional original medical records are enclosed with this Claim.

Molimo da ovaj formular popunite za svako osigurano lice posebno. / Please complete this form separately for each insured person.

IDENTIFIKACIONI PODACI / PERSONAL INFORMATION

PODACI O OSIGURANOM LICU / INSURED PERSON

Ime: *First name:*	Broj polise: *Policy number:*
Prezime: *Last name:*	Br. isprave o dobrovoljnom zdravstvenom osiguranju: *Voluntary Health Insurance Card number:*
Datum rođenja: *Date of birth:*	Adresa: *Address:*
Broj lične karte: *ID card number:*	Broj mobilnog telefona: *Mobile phone number:*
Ugovarač: *Policyholder:*	E-mail adresa osiguranog lica: *E-mail address of the insured person:*

Ja, kao korisnik osiguranja, svojim potpisom na ovom obrascu dajem svoju pismenu saglasnost da se rešenje o pravu na naknadu, obaveštenja i informacije dostavljene od strane osiguravača u elektronskoj formi na gorenavedenu adresu mogu smatrati podjednako validnim kao i dokumenti ispostavljeni u pismenoj formi.

I, the undersigned insurance beneficiary, hereby give my written consent that the decision on the right to a compensation, notifications and information submitted by the Insurer electronically to the specified e-mail address can be considered as valid as the documents submitted in written form.

Datum Date	Opis medicinskog tretmana Description of the medical treatment	Priložen račun/specifikacija br. Enclosed receipt/specification no.	Cena Price
		Ukupan iznos: Total amount:	
		Ugovoreni popust osiguravaču Stipulated discount for the Insurer (_____%):	
		Participacija* osiguranog lica u troškovima Participation* - partial payment of medical service fees by the insured person (_____%):	
		Ukupan iznos za pružaoca zdravstvene usluge: **Total amount for the healthcare service provider:**	

* Ukoliko osigurano lice ima opciju učešća (participacije) u troškovima, ona je navedena na ispravi o dobrovoljnom zdravstvenom osiguranju.
* If the insured person has the option to participate by paying a part of the medical service fee, it is specified on the Voluntary Health Insurance Card.

_____
Datum / Date

Saglasan sam da putem SMS-a na br. telefona naveden u zahtevu dobijem informaciju o plaćanju — DA / YES — NE / NO
I authorize the Company to send me SMS messages with payment information to the phone number specified in the claim

Saglasan sam da elektronskim putem na e-mail adresu navedenu u zahtevu dobijam Pisma obaveštenja i Rešenje o isplati — DA / YES — NE / NO
I authorize the Company to send me Notifications and Payment decision to the email specified in the claim

Ovim izjavljujem da su svi gorenavedeni podaci tačni i istiniti. Ovlašćujem svakog lekara, medicinsku ustanovu, apoteku, osiguravajuće društvo, poslodavca, sindikat ili udruženje da ovaj zahtev prosledi kompaniji Generali Osiguranje Srbija a.d.o. kako bi iznos bio adekvatno isplaćen. U protivnom, nosilac ove polise će sam snositi navedene troškove.
Svojeručnim potpisom potvrđujem da ću, u slučaju da osiguravajuća kuća odbije refundaciju ili je isplati delimično, u skladu sa limitima polise osiguranja, preostali iznos potraživanja refundirati lično pružaocu usluga.
Saglasan sam da se podvrgnem kontrolnom pregledu o trošku Osiguravača i u zdravstvenoj ustanovi prema izboru Osiguravača, a radi revizije stomatoloških usluga koje su mi pružene od strane zdravstvene ustanove iz mreže Osiguravača.
Takođe, svojim potpisom potvrđujem da sam upoznat i saglasan sa činjenicom da će Društvo primeniti posebne mere opreza u pogledu isplata po ugovor u o osiguranju, ukoliko se utvrdi da je ugovarač, osiguranik ili oštećeno lice subjekt primene međunardnih sankcija u skladu sa lokalnim propisima, Rezolucijama Ujedinjenih nacija, propisa Evropske unije ili Sjedinjenih Američkih država.
Svojim potpisom:
- dajem pristanak osiguravaču da obrađuje podatke o mom zdravstvenom stanju u svrhu ispunjenja ugovora o osiguranju;
- oslobađam profesionalne obaveze čuvanja tajne lekare i paramedicinsko osoblje koje me je (moje dete/štićenika) pregledalo pre, u toku i posle nastanka osiguranog slučaja i dajem pristanak zdravstvenoj ustanovi koja mi je (mom detetu/štićeniku) pružila medicinsku uslugu, da saopšti osiguravaču sve neophodne informacije u vezi sa zdrvastvenim stanjem i lečenjem.

I hereby declare that all the above information is true and accurate. I authorize any physician, medical institution, pharmacy, insurance company, employer, union or association to send this Claim to Generali Osiguranje Srbija a.d.o. so that the amount can be paid properly. Otherwise, the policyholder shall personally bear these expenses.
By signing this form I certify that, in case the Insurer declines to refund, or makes partial payment, in accordance with insurance policy limits, I shall personally refund the remaining amount to the service provider.
I hereby give my consent to undergo a medical examination at the expense of the Insurer, at the medical institution of the Insurer's choice, for the purpose of evaluation of the dental services I received at the medical institution from the Insurer's network. I hereby also declare that I am familiar with and accept the fact that the Company shall take special precautions when it comes to payments set out in the insurance contract if it is established that the policyholder, the insured or the claimant is subject to international sanctions in accordance with local regulations, United Nations resolutions, regulations of the European Union or the United States of America.

I, the undersigned hereby:
- authorize the Insurer to process my health information for the purpose of execution of the insurance contract;
- waive doctor-patient confidentiality, regarding the doctors and paramedics who examined me (my child/dependent), before, during and after the occurrence of the insured event, and I hereby grant consent to the medical institution which provided medical service to me (my child/dependent) to disclose to the Insurer all the required health condition and treatment information.

_____
Datum / *Date*

_____
Potpis osiguranog lica (Za maloletna lica, potpis roditelja ili staratelja)
Signature of the insured person (For minors, signature of a parent or legal guardian)