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

Ovaj formular se koristi samo ako se koriste usluge lekara koji NIJE u Mreži pružalaca zdravstvenih usluga. Pošaljite ovaj formular, zajedno sa fiskalnim računom, overenom specifikacijom, nalazima lekara i uputima na adresu koja se nalazi na dnu formulara. Zahtev treba poslati čim vam to zdravstveno stanje dozvoli.

This form is used only for the services of a physician who is NOT part of the healthcare service providers Network. Send this form, with a fiscal receipt, certified specification, doctor's reports and referrals to the address at the end of the form. Send this Claim as soon as your health condition allows you to.

A - IDENTIFIKACIONI PODACI/*PERSONAL INFORMATION*

PODACI O OSIGURANOM LICU (koje je koristilo medicinske usluge)/*INSURED PERSON (person provided with medical services)*

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:*
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.

B - INSTRUKCIJE ZA PLAĆANJE (popunjava osigurano lice)/*PAYMENT INSTRUCTIONS (to be completed by the insured person)*

Uplatu izvršiti: *Payment to be made to:* ☐ Osiguranom licu *Insured person* ☐ Ostalo *Other*	Ime i prezime vlasnika računa: *Full name of the account holder:*
Poslovna banka: *Commercial bank:*	Broj tekućeg računa: *Current account number:* ___ – ___ – ___

Sledeći tretmani i/ili prepisani lekovi su plaćeni i troškovi su navedeni u donjoj tabeli. Priložite **originalne fiskalne račune** i kopiju medicinske dokumentacije da bi vam troškovi bili refundirani.
*The following treatments/prescribed drugs are paid and the expenses are listed in the table below. To obtain a refund of expenses, enclose the **original fiscal receipts** and a photocopy of medical records.*

Datum usluge *Date of service*	Opis usluge i/ili prepisanog leka *Description of service and/or prescribed drug*	Cena *Cost*
	Ukupan iznos plaćen od strane pacijenta: ***Total amount paid by the patient:***	

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

Garantujem 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. Fotokopija ovog formulara smatraće se podjednako važećim kao i original. Potpisom na ovom zahtevu ovlašćujem bilo kog lekara ili medicinsko osoblje, bolnicu ili drugu zdravstvenu ustanovu, socijalno osiguranje ili drugu osiguravajuću ustanovu da osiguravaču, bez moje posebne saglasnosti, daju bilo koju informaciju, istoriju bolesti, medicinsku dokumentaciju o trenutnom i ranijem zdravstvenom stanju u vezi sa konkretnim osiguranim slučajem i službeni dokument ili potvrdu koje osiguravač smatra neophodnim za procenu osnovanosti ovog zahteva za prijavu štete dobrovoljnog zdravstvenog osiguranja. Potpisom na ovom zahtevu potvrđujem da sam u potpunosti upoznat/a sa sadržinom Obaveštenja o obradi podataka o ličnosti i izričito saglasan/na da lične podatke koji su sadržani u ovom zahtevu, kao i sve druge relevantne podatke (uključujući i podatke o zdravstvenom stanju) koji u postupku obrade štete budu utvrđeni i prikupljeni od trećih lica- zdravstvenih ustanova, Generali Osiguranje Srbija a.d.o. može čuvati, obrađivati, koristiti i preneti svojim zaposlenima i reosiguravačima ili saosigurvačima sa kojima bude zaključio ugovor o raspodeli rizika osiguranja, a u svrhu izvršenja obaveza određenih ugovorom o osiguranju. Takođe, potvrđujem da sam izričito saglasan/na da Generali Osiguranje Srbija a.d.o. podatke iz prethodnog stava može čuvati, obrađivati i koristiti u statističke svrhe, u svrhe praćenja rizika u toku trajanja osiguranja i procene rizika pri obnovi ili zaključenju budućih ugovora o osiguranju, kao i da ih može proslediti svim povezanim pravnim licima, članovima svojih organa, trećim licima sa kojima ostvaruje saradnju u postupku likvidacije štete i trećim licima koja po zakonu i prirodi posla koji obavljaju moraju imati pristup tim podacima (Narodna banka Srbije, predstavnici ministarstava i drugih državnih organa, eksterni revizori i sl.). Potvrđujem da sam prethodno upoznat i izričito saglasan da osiguravač može moje lične podatke, i to: ime i prezime, e-mail adresu i broj telefona, obrađivati u svrhu ispitivanja zadovoljstva klijenata – anketiranja, kao i da iste može razmenjivati sa kompanijom Medallia, Ltd. 90 High Holborn, London, WC1V 6XX, sa kojom ima zaključen Ugovor o obradi podataka a radi sprovođenja Projekta analize zadovoljstva klijenata.

I hereby guarantee 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. A photocopy of this Form shall be considered equally valid as the original. I hereby authorize any physician or medical staff member, hospital or another medical institution, social security or another insurance company to issue to the Insurer, without my explicit consent, any information, medical history, medical records on current and pre-existing health condition regarding this insured event and official document or a certificate the Insurer considers necessary to assess the grounds of this Voluntary Health Insurance Claim. I hereby certify that I am fully informed about the content of the personal data processing Notice and I fully authorize Generali Osiguranje Srbija a.d.o., to store, process, use and send to its employees, reinsurers or coinsurers with whom it enters into agreement on insurance risk sharing, the personal data listed in this Claim form and all other relevant information (including the information on health condition) which have been determined and obtained from third parties – medical institutions in the process of claims administration, in order to fulfill contractual obligations set out in the insurance contract. I also certify that I fully authorize Generali Osiguranje Srbija a.d.o. to store, process and use the information referred to in the previous paragraph, for statistical purposes, for the purpose of risk monitoring during the period of insurance, and risk assessment at the time of insurance renewal or conclusion of future insurance contracts, and to forward them to all related legal entities, members of its bodies and third parties with whom it collaborates in the process of claim settlement, and to third parties who, in accordance with the law and by nature of their work, must have access to these data (National Bank of Serbia, ministry representatives and government officials, external auditors, etc.).
I hereby declare that I was informed and I expressly authorize the Insurer to process my personal data: name and surname, e-mail and telephone number, for the purpose of client satisfaction survey, and to share them with Medalia Ltd., 90 High Holborn, London, WC1V 6XX, with which it has signed a Data Processing Agreement for implementation of the Client Satisfaction Analysis Project.

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)