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Prijava odštetnog zahteva dobrovoljnog zdravstvenog osiguranja/ *Voluntary Health Insurance Reimbursement 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
I authorize the Company to send me SMS messages with payment information to the phone number specified in the claim — DA *YES* / NE *NO*

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

Izjavljujem da su svi gore navedeni 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.
Svojim potpisom, odnosno označavanjem polja za pristanak, u slučaju elektronske prijave, potvrđujem da ću, u slučaju da Osiguravač 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, odnosno označavanjem polja za pristanak u slučaju elektronske prijave, potvrđujem da sam upoznat i saglasan sa činjenicom da će Društvo primeniti posebne mere opreza u pogledu isplata po ugovoru o osiguranju, ukoliko se utvrdi da je ugovarač, osiguranik ili oštećeno lice subjekt primene međunarodnih sankcija u skladu sa lokalnim propisima, rezolucijama Ujedinjenih nacija, propisima Evropske unije ili Sjedinjenih Američkih država.
Svojim potpisom, odnosno označavanjem polja za pristanak u slučaju elektronsnke prijave:
- dajem pristanak Osiguravču 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 zdravstvenim stanjem i lečenjem.

I hereby declare that all of the above information is true and correct. I authorise any physician, medical institution, pharmacy, insurance company, employer, trade union or association to forward this claim to Generali Osiguranje Srbija a.d.o. in order for the amount to be adequately paid. Otherwise, the carrier of this policy shall bear the stated expenses.
I confirm with my signature, namely by marking the acceptance check box in the case of an electronic claim, that I will personally refund the remaining amount of the claim to the service provider if the Insurer declines the refund or makes a partial reimbursement.
I agree to undergo an examination at the cost of the Insurer at the health facility selected by the Insurer, for the purpose of revision of dental services provided to me by the health facility of the Insurer's network. I also confirm with my signature, namely by marking the acceptance check box in the case of an electronic claim, that I am aware of the fact that the Company will take special precaution measures as regards the payment according to insurance contract if it is established that the insuring party, insurer or claimant is subject to international sanctions in accordance with local regulations, UN Resolutions, EU or US Regulations.
With my signature, namely by marking the acceptance check box in the case of an electronic claim:
- I authorise the Insurer to process the data of my health condition for the purpose of fulfillment of insurance contract;
- I release the physicians and paramedics who examined me (my child / dependent) from the duty of professional confidentiality before, during, and after the occurrence of the insured event, and authorise the health facility that provided the medical service to me (my child / dependent), to reveal all necessary information to the Insurer regarding health status and treatment.

Dajem pristanak/*Approve*

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)