



ERGO Life Insurance SE
 Company code 110707135
 Geležinio Vilko g. 6A, 03507, Vilnius
 Tel: (8 5) 268 3035, Fax: (8 5) 268 3035
 Insurance policy number:

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Name and surname: _____

Personal identification code: _____ Telephone number: _____

E-mail address: _____

Address: _____

APPLICATION

Please reimburse my health insurance expenses for the following services (please mark):

- | | |
|--|---|
| <input type="checkbox"/> Outpatient treatment and diagnostics | <input type="checkbox"/> Ophthalmic goods |
| <input type="checkbox"/> Inpatient treatment | <input type="checkbox"/> Prenatal care |
| <input type="checkbox"/> Medicines, medical aids, orthopaedic articles | <input type="checkbox"/> Preventive health check |
| <input type="checkbox"/> Food supplements and over-the-counter medicines | <input type="checkbox"/> Vaccination |
| <input type="checkbox"/> Rehabilitation treatment | <input type="checkbox"/> Wellness services |
| <input type="checkbox"/> Orthodontic services | <input type="checkbox"/> Other medicinal services |

Total amount paid: _____ Please reimburse _____

I hereby agree that during the investigation of the insured event ERGO Life Insurance SE may verify and assess information and documents provided by me and for this end may interview all doctors, health care, nursing, and wellness institutions, sports clubs, and other institutions that provided the services and may obtain from them information and documents about my treatment, health condition, diagnoses, wellness services provided to me, and any other personal information about me as a patient and/or consumer of wellness services. I agree that health care and wellness institutions, sports clubs, and other institutions that provided services to me may disclose the said information.

I hereby agree that the personal information provided in this application or the personal information revealed during the conclusion of the insurance contract in which I am the insured person, during the investigation of the insured event may be stored and otherwise handled by ERGO Life Insurance SE for the purpose of risk assessment, administration and fulfilment of the insurance contract in which I am the insured person, and investigation of insured events and for the same purpose may be transferred to insurers, insurance brokers, health care, nursing, and wellness institutions, sports clubs, and other persons whereby the law and other legal acts define procedures for collecting and provision of such information and recipients of such information.

I have been informed about my right to familiarise myself with my documents handled by the insurer and the way they are handled and to require correction or destruction of my personal documents or suspension of the procedures for handling my personal documents if the information is handled by breaching provisions of the law and to deny handling of my personal information.

Name, surname, and signature: _____

Date: _____

Please transfer payment to:

Bank:

Account No: _____

Name and surname of the account holder: _____

Personal identification number of the account holder : _____

A list of the required documents: 1. An invoice (issued in the name of the insured person) with a receipt (if payment was made by transfer, a statement of payment) or cash receipt or a receipt of the purchase/sale of goods/services. 2. Medical documents that contain the reason for contacting the doctor, health disorders diagnosed, tests and treatment received (a copy from the patient's case history or an extract form 027/a) 3. Doctor's prescriptions to perform tests and the reason for such testing. 4. Doctor's prescriptions for treatment procedures or tests with the name of the diagnosis and procedures and tests prescribed to the patient. 5. Medical documents about orthodontic treatment (a copy from the patient's orthodontic file). 6. A prescription in the form approved by the Ministry of Health of Lithuania or a copy thereof (when the chemists must retain the original prescription) for medicines, medicinal aids, and orthopaedic articles. 7. Ophthalmic doctor's prescription for contact lenses or lenses for ophthalmic glasses. 8. A copy of the business certificate (if services are provided by a person operating under the business certificate). 9. Completed counterfoil of the health insurance book.

I have familiarised myself with the list of the documents above; I understand that submission of these documents is required for investigation of the insured event; and I agree that employees of ERGO Life Insurance SE may require any additional information, if necessary, for investigation of the insured event.

Name, surname, and signature: (date)