ERGO Life Insurance SE. Company code 110707135
Geležinio Vilko g. 6A, LT-03507 Vilnius
Tel. (8 5) 268 3000, Fax (8 5) 268 3035

ERGO

Request for reimbursement of health insurance expenses

Data of the Insured

Insurance policy number or insurance card number

Policyholder

Name, surname

Personal number

E-mail address

Telephone number

Address

Insured Event (please indicate)

- ☐ Ambulatory treatment (consulting, tests)
- ☐ Pregnancy care
- ☐ Food additives, non-prescription drugs
- ☐ Odontology
- ☐ Preventive check-up (by nature of work, consulting, tests without the doctor's prescription)
- ☐ Vaccination
- ☐ Rehabilitation services (physiotherapy, massage, kinesitherapy with the doctor's prescription)
- ☐ Wellness services (physical exercises, massage, water procedures)
- ☐ In-patient services (in hospital)
- ☐ Drugs (with prescriptions)
- ☐ Optical products (with the doctor's prescription)
- ☐ Other medical services

Total amount paid by me

Amount in words

Treatment of serious diseases ☐ In-patient treatment ☐ Ambulatory treatment ☐ Rehabilitation treatment ☐ Drugs

Treatment after accidents ☐ Dental treatment ☐ Rehabilitation treatment

Total amount paid by me

Amount in words

Insurance Benefit Payment by Bank Transfer (please indicate the details)

Account No. (L T)

Bank name

Account holder's name, surname

Account holder's personal number

By filling-out and sending this request I hereby confirm that:

1. The above indicated data is my personal and contact data and, in case my request is filled out electronically and submitted to the Insurer by e-mail, I agree that the Insurer has the right to use my indicated personal and contact data when requesting the suppliers of products/services to submit, confirm or explain information about services and/or products provided to me.
2. All information submitted by me in this request and in the documents attached to this request is correct and I realise that in case the information submitted is incorrect or misleading, the Insurer has the right to refuse to pay the benefit and that I may be held liable for submitting incorrect information in accordance with the procedure set forth by the legal acts of the Republic of Lithuania.
3. I am aware of the list of documents to be submitted to the Insurer to confirm the services provided to me and the expenses for the provided services as indicated in Paragraph 10.5 of the Insurer's Health Insurance Regulations No. 010. I realise that submitting of these documents is required for the insured event investigation and I agree that the employees of the insurance company may request to submit other additional information if so required for the insured event investigation and for defining and payment of the insurance benefit amount.
4. I agree that the Insurer verifies and evaluates my submitted personal data, other information and documents to evaluate the insurance risk and/or to investigate the insured event and for this purpose interviews all doctors, healthcare, nursing, wellness institutions and sports clubs or other institutions or enterprises which provided services to me, submits my personal data to them and obtains information and documents from them relating to my treatment, health condition, diagnosis, healthcare services, wellness services provided, and also all other information of personal character about me as a patient and/or user of wellness services. I agree that healthcare, wellness institutions, enterprises, sports clubs and other institutions which provided services to me disclose the aforementioned data to the Insurer.
5. My personal data submitted herein and my personal data which comes out when making the insurance agreement wherein I stand as the insured, when investigating the insured event is saved or otherwise handled by the Insurer for the insurance risks evaluation purposes, administration, implementation of the insurance agreement wherein I stand as the insured, insured events investigation and for the same purposes is handed over to the insurers, insurance brokers, healthcare, nursing, wellness institutions, sports clubs, and also to other persons in cases where the laws or other legal acts define the procedure for collecting and submitting such data as well as the data recipients, and receives my personal data from them and handles them for the indicated purposes;
6. I am aware of my right to familiarise myself with my handled data and to the way it is handled, to demand to correct, destroy my personal data or to suspend the actions of handling my personal data in case the data is not handled in compliance with the provisions of the laws, and not to agree to handling my personal data;
7. I undertake to keep the original copy of this request and of the documents attached to this request (in case copies were sent to the Insurer) for 3 (three) years and, at the Insurer's request, to deliver them immediately.

I agree that all information related to the benefits for the services/products provided to me is sent by e-mail: ☐ Yes ☐ No
I undertake to notify the insurance company of the change of my e-mail address within one workday.

Name, surname, signature

Date

Please send the documents by e-mail sveikatos_zalos@ergo.lt or by mail to ERGO Life Insurance SE, Geležinio Vilko g. 6A, LT-03507 Vilnius.

To be Filled out by the Company'S Employee

Benefit No. (ID)

Benefit amount, Eur

Date

Signature and seal