ИНГОАРМЕНИЯ
IngoArmenia

Personal accident claim application form

Claim number: _____

Please provide us with the information requested below.

1. DISEASED PLAN MEMBER DETAILS		
Insured		Policy number
First name, Last name		
Insurance card ID		
Full passport details (number, date of issue, who has provided)		
Date of birth		
Residence address		
Telephone numbers		
E-mail address		
Plan member relationship to insured	☐ Insured Employee ☐ Employee's spouse ☐ Employee's child ☐ Other_____	
2. INSURANCE EVENT		
Date, place and time of accident		
Accident Description		
Was it reported to the Police or appropriate bodies? If Yes, please attach a copy of the report or give the details of the report and its number	☐ Yes_____ ☐ No	
Whom do you consider responsible for the accident? If the other party, please give the details.		
Are you making any claim against the other party's regarding compensation of you loss?	☐ Yes_____ ☐ No	
3. MEDICAL INSTITUTION VISIT AND TREATMENT		
The name of medical institution		
Address/ telephone number of the medical institution		
Name and surname of physician		
4. CLAIM IS TO BE PAID		
☐ To Insured Person ☐ To Heirs - as per acting legislation: heirs. ☐ To Beneficiary - as per beneficiary's appointment card		

5. THE INDEMNITY IS PAYABLE BY

☐ According to Passport details transfer to the current bank account

☐ Ararat Bank

_____

(Please indicate Full passport details (number, date of issue, who has provided) of the recipient)

☐ Other _____

(Please indicate Bank, branch / Address)

☐ Bank transfer (please indicate bank details of the Insured person mentioned under the point 1 of this Application)

- Bank/ Account number _____
- Account holder's name _____

DECLARATION

Hereby I confirm that all the documents and information inclusive of any annexes provided with this Application is complete, correct, accurate and true and all annexes attached to it. I understand that any provision of false or obviously incorrect information may lead to application rejection, whereas provision of false information and/or documents will lead to liability envisaged by the law.

I hereby grant the medical institutions, to provide any and all necessary documentation to "INGO ARMENIA" ICJSC in regards to my treatment and diagnosis, for the purposes of resolving and adjusting my claim.

Date	Applicant (first name, last name) / Signature /	If the applicant is not the Insured, please indicate the relationship with the Insured. ☐ Spouse ☐ Parent ☐ Other (please indicate) _____