Colonnade Insurance SA Luxembourg – Sucursala Bucureşti UIC: 38335135
145th Calea Victoriei, Victoria Center Building, 8th floor,
1st District, 010072, Bucharest, Romania
+4021 300 96 21
office@colonnade.ro
www.colonnade.ro

CLAIM FORM

If you will follow these simple instructions, we will be able to give your claim immediate attention when we receive this form.

- If you have suffered a condition covered by your policy, please complete this claim form as soon as possible after the diagnosis and the treatment in a hospital. Answer every question completely and accurately, than give this form to your doctor.
- Ask your treating doctor to answer to all the questions on the reverse side and return this form to the Colonnade Insurance SA office.
- Attach all the original bills and certificates issued by the hospital, and the documents requested by your insurance policy.
- It is not necessary to contact directly the Colonnade Insurance SA agents. After the form is completed both sides, please send all the medical documents to the Colonnade Insurance SA office on the address mentioned above.
- Naturally, the furnishing of a claim form does not constitute an admission of liability.

Policy number: _____ Inception date of the policy:_____

Full name of Policy Holder: _____

Full name of Patient (if different of the Policy Holder):_____

Date of birth: _____ (day, month, year)

Address: _____ City/County:_____

1. Diagnosis of injury or sickness: _____

_____

2. If sickness, when did symptoms first appear? _____(Day, month, year)

3. If injury, when did accident occur? _____ (Day, month, year)
Mention the number and the date of the police report or the finding documents of the employer:_____

4. When did you first see a doctor for this condition? _____(Day, month, year)

Doctor's name and address: _____

5. Data hospitalised (admitted):_____ Discharged: _____

Name and address of Hospital: _____

6. Have you ever seen a doctor for this or a similar condition in the past? • Yes • No
(If yes, give dates, names and addresses of doctors):_____

7. Name and address of regular family physician: _____

8. What other sicknesses or accidents have you had in the past 3 years?

_____

Signed: _____ Date: _____

I hereby authorise any hospital, physician, or other person who has attended me to furnish to Colonnade Insurance SA or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, and copies of all hospital and medical records. I agree that a photostatic copy of this authorisation shall be considered as effective and valid as the original.

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ATTENDING PHYSICIAN'S STATEMENT

Name of the doctor signing the statement:_____

Patient's name:_____ Age:_____

1. If injury, when did accident occur?_____(Day, month, year)

If sickness, when did symptoms first appear ?_____(Day, month, year)

2. Diagnosis, chief complaint,

history,complications:_____

_____

_____

_____

3. When did patient first received medical attention for the above?_____ (Day, month, year)

By whom:_____(Name and address)

4. Date hospitalised: Admitted_____ Discharged_____

5. What operation, if any, was performed:_____

6. Was confinement in a convalescent home necessary after hospitalisation? • Yes • No

If yes, give dates: from_____ to: _____

7. Has patient ever had same or similar condition? • Yes • No

8. Have you previously treated this patient? • Yes • No

If yes, when and for what?_____

_____

9. What defects or chronic diseases does the patient have and when did they originate? _____

_____

_____

Date: _____ Signature: _____

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Form of consent

By providing your Personal Information to Colonnade Insurance SA in connection with your claim, you consent to the collection and processing (including the use and disclosure) of your Personal Information as described in this Privacy Policy available at https://www.colonnade.ro/en/ or upon request at dpo@colonnade.ro. In particular, you consent to the transfer of your Personal Information internationally. You agree that you will not provide Personal Information about any other individual without that person's permission. Alternative: To the extent that you have provided (or will provide) Personal Information to Colonnade Insurance SA about any other individual, you certify that you have provided information to the individual about the content of this Privacy Policy and you are authorized to disclose his or her Personal Information to Colonnade Insurance SA as detailed in the Privacy Policy.

Signature: _____

Name: _____

Date: _____