DDOR OSIGURANJE | Unipol

Akcionarsko društvo za osiguranje "DDOR Novi Sad" Novi Sad
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Agencija za privredne registre Republike Srbije, Registar privrednih subjekata
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"DDOR Novi Sad" a.d.o. Novi Sad je deo Unipol Assicurazioni S.p.A. registrovanog u odgovarajućem registru grupa Republike Italije.

Prijava štete dobrovoljnog zdravstvenog osiguranja / Claim notification for voluntary health insurance

Ovaj obrazac se upotrebljava u slučaju korišćenja zdravstvenih usluga u/van Mreže zdravstvenih ustanova sa kojima Osiguravač ima zaključen ugovor o pružanju zdravstvenih usluga ili za refundaciju troškova za prepisane lekove i medicinska pomagala /
This form is used in case of using health services in/outside of the Network of health institutions with which the Insurer has a concluded contract on providing health services, or for refund of expenses for prescribed medications and medical aids.

Na adresu **DDOR Osiguranje, Poštanski pregradak 392, 21101 Novi Sad** ILI **DZOrefundacije@ddor.rs** dostavite /
To the address **DDOR Osiguranje, PO Box 392, 21101 Novi Sad** OR **DZOrefundacije@ddor.rs** please send:

popunjen obrazac za prijavu štete / filled out claim notification form	kopiju izveštaja lekara / copy of doctor's medical report
kopiju fiskalnog računa / copy of fiscal receipt	
kopiju isprave dobrovoljnog zdravstvenog osiguranja / copy of the voluntary health insurance card	

IDENTIFIKACIONI PODACI / PERSONAL DATA

Ime i prezime osiguranika / Name and surname of the insured:	
Ugovarač osiguranja / Policyholder:	Polisa broj / Policy no.:
JMBG:	Kontakti telefon / Phone number:
Datum rođenja / Date of birth:	Adresa / Address:
Isprava broj / Card no.:	E-mail:

INSTRUKCIJE ZA PLAĆANJE / PAYMENT INSTRUCTIONS

Ime i prezime korisnika osiguranja / Name and surname of insurance beneficiary:	
JMBG:	Adresa / Address:
Poslovna banka / Commercial bank:	Broj tekućeg računa / Current account no.:

LEKARSKI TRETMANI, PREPISANI LEKOVI, MEDICINSKA POMAGALA / MEDICAL TREATMENTS, PRESCRIBED MEDICATIONS, MEDICAL AIDS

DATUM USLUGE / DATE OF SERVICE	NAZIV IZVRŠENE MEDICINSKE USLUGE / NAME OF THE MEDICAL SERVICE PROVIDED	IZNOS / AMUNT
	UKUPNI TROŠKOVI / TOTAL EXPENSES:	

U svojstvu osiguranika i/ili oštećenog, svojim potpisom potvrdjujem da sam upoznat da će Akcionarsko društvo za osiguranje "DDOR Novi Sad", Novi Sad, Bulevar Mihajla Pupina 8. (u daljem tekstu: Osiguravač), moje podatke o ličnosti sadržane u zahtevu za isplatu štete, kao i sve druge relevantne podatke utvrdjene i prikupljene od trećih lica, u postupku obrade štete čuvati, obrađivati, koristiti i preneti svojim zaposlenima i trecim licima sa kojima Osiguravač ima zakljucen ugovor o pružanju usluga, reosiguranju ili saosiguranju, a u svrhu izvršenja obaveza iz ugovora o osiguranju. Svojim potpisom nedvosmisleno potvrđujem da sam izričito saglasan da Osiguravač podatke o ličnosti iz prethodnog stava može čuvati, obrađivati i koristiti u statističke svrhe, u svrhe praćenja rizika u toku trajanja osiguranja i procene rizika pri obnovi ili zakljucenju budućih ugovora o osiguranju, kao i da ih može proslediti svim članicama grupacije UNIPOL, članovima svojih organa, svojim akcionarima, zaposlenima, trećim licima sa kojima Osiguravač uspostavlja saradnju u postupku rešavanja zahteva za naknadu štete i trećim licima, koja po zakonu i prirodi posla koji obavljaju moraju imati pristup tim podacima. Upoznat sam sa načinom i rokovima čuvanja podataka, kao i pravom na opoziv date saglasnosti pismeno, ili usmeno na zapisnik, uz saznanje da povlačenje pristanka može onemogućiti Osiguravača da realizuje obaveze po ugovoru o dobrovoljnom zdravstvenom osiguranju /
In the capacity of the insured and/or claimant, by signing this I confirm that I am aware that Joint Stock Insurance Company "DDOR Novi Sad", Novi Sad, Bulevar Mihajla Pupina 8 (hereinafter: Insurer), will keep, process and use my personal data contained in the claim, as well as all other relevant data established and collected by third parties in the process of claim processing, and transfer them to its employees and third parties with which the Insurer has a concluded contract on provision of services, reinsurance or coinsurance, for the purpose of execution of obligations from the insurance contract. By signing this, I affirm unequivocally that I expressly agree that the Insurer can keep, process and use the above personal data for statistics purposes, for monitoring risks during the insurance period and for risk assessment during renewal or conclusion of future insurance contracts, and that the Insurer can forward such data to all UNIPOL Group members, members of its bodies, its shareholders, employees and third parties with which the Insurer establishes cooperation in the process of settling the claim, and to third parties who, by law and nature of their work, must have access to such data. I am familiar with the method and periods of data keeping, as well as the right to revoke the given consent in writing or verbally for the record, knowing that revoking the consent could prevent the Insurer from realising the obligations from the contract on voluntary health insurance.

Mesto i datum prijave štete / Place and date of claim notification

Potpis osiguranog lica / Signature of the insured person

ZDRAVO DA STE
DOBROVOLJNO ZDRAVSTVENO OSIGURANJE

DOBROVOLJNO ZDRAVSTVENO OSIGURANJE

MEDICINSKI KONTAKT CENTAR
021 480 22 00
zdravodaste@ddor.rs
www.ddor.rs/zdravodaste