ADB Gjensidige, Department of Claims, Eigulių g. 21, Vilnius.
Telephone 1626. E-mail: zalos.sveikata@gjensidige.lt. www.gjensidige.lt

(Insured person's name and surname)

(FIN ID number)

Address, telephone number

Email address

## REQUEST FOR PAYMENT OF THE INSURANCE BENEFIT

I request you herewith to pay out the insurance benefit to cover the health insurance costs on (please indicate):

☐ Outpatient treatment _____ Eur
(please submit the documents referred to in items 1-3 below)

☐ Inpatient treatment _____ Eur
(please submit the documents referred to in items 1-3 below)

☐ Medical rehabilitation _____ Eur
(please submit the documents referred to in items 1, 2, 3 and 5 below)

☐ Prenatal care and childbirth _____ Eur
(outpatient prenatal care)
(please submit the documents referred to in items 1, 2, 3 and 5 below)

☐ Odontology _____ Eur
(please submit the documents referred to in items 1, 2 and 3 below)

☐ Medicines and medical supplies _____ Eur
(please submit the documents referred to in items 1, 2 and 6 below)

☐ Vitamins _____ Eur
(please submit the documents referred to in items 1 and 2 below)

☐ Optics (optical products) _____ Eur
(please submit the documents referred to in items 1, 2 and 4 below)

☐ Preventive health examinations _____ Eur
(please submit the documents referred to in items 1-2 below)

☐ Vaccines (immunoprophylaxis) _____ Eur
(please submit the documents referred to in items 1-2 below)

☐ Acute illness insurance _____ Eur
(please submit the documents referred to in items 1-3 below)

☐ Critical illness insurance _____ Eur
(please submit the documents referred to in items 1, 2 and 5 below)

☐ Health promotion services _____ Eur
(please submit the documents referred to in items 1, 2 and 5 below)

☐ Free settlement/ All risks insurance *Alfa* or *Beta* (free settlement) _____ Eur
(please submit the documents referred to in items 1, 2 and 5 below)

Requested payment in total: _____ Eur*
*the amount of the insurance benefit shall be calculated in accordance with the terms and conditions set forth in the insurance contract.

List of the documents to be submitted:
**1.** Invoice (issued to the insured person) which indicates purchased goods or provided services explicitly. **2.** Payment document: cash receipt, cheque or any other payment document where payment was effectuated by transfer. **3.** Excerpt from medical documents on the established health disorder, prescribed medical examinations and findings. **4.** Eye doctor's prescription for spectacle lenses or contact lenses. **5.** Copy of a business licence (where the provider of services was a person working with a business licence). **6.** Doctor's prescriptions (e-prescriptions) for medicinal preparations or medical aids.

**I request you herewith to transfer the insurance benefit to the following bank account:**
Bank account number

Name of a bank

SWIFT Code

Personal ID number of the holder of account

(Name and surname of the holder of account)

I consent herewith that ADB Gjensidige or its authorized third persons use the data submitted by me and/or contact the healthcare institutions, health insurance funds, law enforcement institutions and other third persons that have requisite information (also about my health condition) and that the latter provide information which is necessary to evaluate the events that occur during the term of the contract and calculate the amount of benefits.

(Insured person's name, surname and signature) (Date)

**Representative of ADB Gjensidige** (Date)