I. GENERAL PROVISIONS

Article 1. This Policy governs the procedures under which BULSTRAD LIFE VIENNA INSURANCE GROUP JSC accepts the claims under insurance contracts, collects the evidence to establish their grounds and amount, determines the amounts of insurance payments, makes payments to users of insurance services and investigates complaints regarding these claims.
Article 2. The Policy for the Activity of BULSTRAD LIFE VIENNA INSURANCE GROUP JSC in relation to the Settlement of Claims regarding Insurance Contracts is prepared in accordance with the Insurance Code and the General Terms and Conditions of Insurance offered by the insurer.
Article 3. The Policy for the Activity of BULSTRAD LIFE VIENNA INSURANCE GROUP JSC in relation to the Settlement of Claims regarding Insurance Contracts shall hereinafter be referred to as the Policy; the persons filing the claim – Users of Insurance Services and BULSTRAD LIFE VIENNA INSURANCE GROUP JSC - as Insurer.
Article 4. The term "insurance amount" shall mean one of the following:
1. insurance amount in the event of survival, death or permanently reduced or lost working capacity of the insurant;
2. share of the insurance amount in the event of temporary, permanently reduced or lost working capacity of the insurant or compensation in case of medical expenses incurred by the insurant or redemption of the contract;
3. insurance payment in the event of hospitalisation, medical expenses, temporary loss of working capacity, rent payments, etc., as per the conditions of the insurance policy.
Article 5. The documents required for filing insurance payments are listed in Appendices 1 to 12, which constitute an integral part of this Policy.

II. COURSE OF THE CLAIM

Article 6. The claim shall be submitted to the Head Office of the Insurer, the agencies or offices of the Company, in writing, by filling in an application form of the Insurer (electronic or paper), by the User of Insurance Services, their legal successor or representative or the beneficiary under the insurance.
Article 7. The application under Article 6 can be found on the Insurer's website: www.bulstradlife.bg. It is a mandatory document when filing a claim for payment of the insurance amount under the contract and may be submitted every working day from 9:00 am to 5:30 pm in the offices of the Insurer, by courier or electronically in the application form of the Insurer where such is provided. If a client is insured under more than one insurance contract regarding which they wish to file a claim, they shall fill in a separate Application for each insurance contract.
Article 8. The Application shall indicate the names, correspondence address and e-mail address if the User of Insurance Service wishes to receive the messages regarding the insurance claim electronically.
Article 9.(1) Upon receiving a claim for payment of an insurance amount, the Insurer, depending on the insurance event that has occurred, shall verify the information filled in the application and the documents submitted by the applicant. If necessary, the Insurer shall request any additional information and documents from the User of Insurance Service or their legal representatives or heirs in accordance with the relevant Appendix, part of this Policy.
(2) If a special investigation and additional evidence not provided for in the insurance contract are necessary for the clarification of the reasons and circumstances of the occurrence of the insurance event, the Insurer shall inform the insurant/beneficiaries under the insurance contract of the additional evidence no later than 45 (forty-five) days after the submission of the evidence specified in the insurance contract and this Policy.
(3) The Insurer shall notify the user of the insurance service in writing of any additional documents necessary to establish in an indisputable manner the grounds and amount of the claim, at the address provided by the user at the time of filing the claim.
Article 10. Where the Insurer directly requests additional information from judicial institutions, trusted doctors, hospitals, investigative bodies, employers, etc., they shall notify the beneficiary in writing about the requested information.
Article 11. The receipt of the initially and additionally presented evidence shall be certified by the Insurer with an incoming number and date. The documents presented under each insurance claim shall form the claim file.
Article 12. (1) The documents under Appendices No 1 to 12 shall be presented in original and, if objectively impossible to be presented in original, they shall be attached as copies certified at a notary's office.
(2) If any of the documents are in a foreign language, they shall be presented to the Insurer translated into Bulgarian and certified by a sworn translator.
(3) The Insurer may accept a copy of a document at their discretion.
Article 13. After the documents are submitted to the Insurer's Head Office, they shall be directed to the Liquidation Department. Depending on the type of insurance product, this can be either Liquidation Life Insurance or Liquidation Health Insurance.
Article 14. Each insurance claim shall be registered in the Company's information system and shall be given a unique number. All documents received and sent by the Company related to the claim shall form the insurance file.
Article 15. (1) Each insurance claim shall be considered and processed by an employee of the Liquidation Department who shall enter the data into the information system of the company, review the information submitted regarding the file, make a preliminary assessment of the claim based on the available documentation related to the insurance event, verify the status of the insurance policy in the information system, the terms of the concluded insurance contract and assess the need for additional evidence.
(2) Any claim requiring an additional medical opinion in accordance with the insurance amount shall warrant a consultation with a trusted doctor of the Insurer who shall issue a written reasoned opinion regarding the case. If the trusted doctor considers that the documents provided are incomplete or insufficient to clarify the claim, the doctor may recommend in writing that additional documents be requested. The written statement of the trusted doctor shall be included in the insurance file.
(3) Depending on the nature and complexity of the claim, a consultation may be performed in relation to it with an expert from the Legal Department, an actuary, a financial and accounting expert or an external expert in the listed areas with whom the Company has concluded a contract. In these cases, the written statement of the respective expert shall be included in the insurance file.
Article 16. The expert from the Liquidation Department shall provide an opinion regarding the file as follows: in "an insurance claim report" in the cases where a decision has been made to pay an insurance amount or insurance compensation in full or in part or in an "opinion on the case" in the event of the claim being refused. In the latter case, the expert shall provide reasons for his/her decision.
Article 17. The amount of taxes, fees, etc. that exist or will be established on the amount of the insurance payment shall be determined in accordance with internal procedures prepared in accordance with the requirements of the Bulgarian legislation.
Article 18. Based on the prepared Insurance Claim Report, the Accounting Department shall make the payment to the bank account provided by the beneficiary. The bank account shall be in a bank operating on the territory of Bulgaria or the European Union.
Article 19. (1) The insurance amount under the insurance claim shall be determined in accordance with the terms of the insurance contract and shall be payable

by the Insurer to the beneficiaries specified in the insurance policy or the beneficiaries provided for by law.
(2) Payment from an insurer to a User of Insurance Services through a third party shall be allowed only on the basis of an explicit written power of attorney with the signatures certified at a notary's office regarding the relevant insurance claim or payment stating that the user of insurance services has been informed that they are entitled to receive the payment personally, to a bank account. If the third party is an insurance intermediary, payment under the insurance claim shall be made only to the client's account of the person.
Article 20. Upon early termination of the policy, the policyholder shall be entitled to receive the redemption value from the Insurer.
(1) The condition for receiving the redemption shall be that at least two full insurance years have elapsed since the beginning of the insurance coverage and the premiums have been paid according to the terms and amounts specified in the insurance contract. The requirement that at least two years have elapsed shall not apply where 15 per cent or more of the insurance premiums have been paid. The amount of the redemption value is defined in the General Terms and Conditions of the insurance.
(2) The entitled person shall file a claim for payment of a redemption amount by submitting a redemption application. The redemption application shall be accepted by the Insurer with an incoming number and date being placed thereon and the redemption value shall be calculated as at this date (the date of the Redemption Application). The redemption value shall be paid to the bank account provided by the person entitled to receive the redemption.

III. CLASSIFICATION OF THE CLAIMS

Article 21. (1) Once registered in the information system, the claim shall be classified into one of the following sections:
1. **Unprocessed Claims Section** – it includes any claim registered in the information system that has not yet been evaluated by an expert liquidator.
2. **Paid Claims Section** – it includes any claim for which an insurance amount has been paid if all the conditions of the insurance contract have been met, the documents presented undoubtedly prove the amount and reasonableness of the claim and the conditions of this Policy are met.
3. **Stagnant Claims Section** – it includes any claim regarding which a decision cannot be made on whether to make a payment or to justify a rejection of the claim because of a lack of information certifying its reasonableness and/or amount. These files shall include the additional information required. The Insurer shall undertake to inform the beneficiary in writing of the additional information and evidence to be provided, detailing in writing the type of such information (for example: questionnaire sheet; medical history; Personal Outpatient Card (POC); statements by the Road Traffic Control Office, etc.). No later than 6 (six) months as of the date of filing the claim, regardless of whether or not the beneficiary has provided the additional information requested by them, the Insurer shall undertake to make a decision by paying the insurance compensation or giving reasons for their refusal in writing.
4. **Rejected Claims Section** – this category includes the damages regarding which the Insurer has decided to reject the claim by giving reasons for their decision in writing to the beneficiary.
5. **Terminated Claims Section** – this category includes cases where the person entitled to receive an insurance amount or compensation has renounced his/her right or has withdrawn his/her application.
6. **Expired Claims Section** – this category includes cases that have expired according to the Insurance Code.
(2) The Insurer shall undertake to send to the User of Insurance Services a reasoned reply in case of refusal to pay the claimed insurance amount.
Article 22. (1) The insurance amount or a corresponding part thereof shall be paid only by bank transfer within 15 (fifteen) business days of the date of submitting all necessary documents to the Insurer, which shall be proved by an incoming number according to the inventory of the Company.

IV. REVIEWING CLAIMS

Article 23. Within the meaning of this Policy, "complaint" shall be a written complaint, regardless of its title, for dissatisfaction or disagreement by a User of Insurance Services against the services provided by the Insurer, including decisions on liquidation files and complaints/disagreements by/with the behaviour of employees, insurance intermediaries or other persons acting on behalf of the Company.
Article 24. (1) Where the beneficiary does not agree with the refusal or the amount of the insurance payment, they may file a written complaint stating their objections and presenting new evidence in support thereof. Article 6 of this Policy shall apply to the method of submission.
(2) Any person may file a complaint and recommendation in any of the following ways:
1. through the contact form on the Company's website at www.bulstradlife.bg;
2. by e-mail to delovstvo@bulstradlife.bg;
3. at each office of BULSTRAD LIFE VIENNA INSURANCE GROUP JSC, as well as at the address of the Head Office: 1301 Sofia, 6 Sveta Sofia Str.;
4. in writing, by mail sent to: 1301 Sofia, 6 Sveta Sofia Str.
(3) Bulgarian shall be the official language of the complaints, inquiries, alerts and recommendations. Documents submitted in a foreign language shall be accompanied by an accurate translation into Bulgarian.
Article 25. The Insurer shall maintain a register of the submitted complaints. All written complaints received at BULSTRAD LIFE VIENNA INSURANCE GROUP JSC shall be registered on the day of their submission if received within the working hours of the Company and in all other cases – on the next working day; they shall be allocated by competence to the relevant responsible unit of the Company.
Article 26. The complaint shall be submitted to the Insurer in free-form text and must include the following minimum details:
1. description of the objection and formulation of the request (in the case of a complaint); description of the inquiry; description of the irregularity found or description of the weakness identified and recommendation for its improvement;
2. insurance policy number (ID card number for clients with Healthcare Insurance) or insurance claim number if applicable;
3. details of the sender as follows:
3.1. for local natural persons – full name and Personal No;
3.2. for foreign individuals – names, Personal No/Personal No of Foreigner or data from another valid similar document
3.3. for legal entities – name of the legal entity, UIC, data about the persons who can manage and represent it;
4. signed Confidentiality Notice as required by Regulation (EU) 2016/679 of the European Parliament;
5. correspondence address (postal and/or electronic) and telephone number;
6. a list of the attached documents, if any;
7. signature of the person filing the complaint or his/her legal representative or proxy, if presented on paper.
Article 27. (1) Upon submission of a complaint regarding a claim at the Head Office of the Insurer, it shall be referred to the Liquidation Department. The expert concerned shall become acquainted with the reasons for the complaint and shall draw up a written response within seven days in order to legally and factually justify the determined amount of the insurance payment. Where the complaint is against a total refusal of the Insurer related to the grounds of the claim, the

deadline for making a decision shall be 30 days as of the date of its receipt.
(2) Where the case is of high legal and factual complexity, the response to the complaint shall be agreed with a legal counsel. Where the complaint refers to questions requiring an expert opinion of a physician or other person, the response shall be agreed with the relevant expert.
(3) Where the complaint is submitted through the Financial Supervision Commission (FSC), the Insurer shall make a decision within the time limits specified in the inquiry from the FSC. In the event of a change in the initial decision on a complaint filed through the FSC, the Insurer shall notify both the Commission and the complainant in writing.

V. CONFIDENTIALITY IN SETTLEMENT OF INSURANCE CLAIMS

Article 28. The activity of settling insurance claims at BULSTRAD LIFE VIENNA INSURANCE GROUP JSC shall be carried out in accordance with the accepted internal rules of confidentiality available on the Company's website at www.bulstradlife.bg.
Article 29. Personal data in the procedure for settlement of insurance claims, including the health data of the User of Insurance Services shall be processed without the need of explicit consent. The data shall be processed solely for the purpose of settling insurance claims and fulfilling our obligations under the terms of the insurance contract and exclusively for the benefit of the users of insurance services for the purpose of the Insurer making a decision regarding the claim.
Article 30. When filing an insurance claim, the User of Insurance Service shall become acquainted with and accept the Privacy Notice, which shall become an integral part of the insurance file.
Article 31. The Privacy Notice can be found on the insurer's website: **www.bulstradlife.bg**; where the person submits the application and the documents regarding the insurance claim by mail or courier, it is necessary for him/her to read in advance the full text of the notice uploaded on the website of the Insurer and confirm this by affixing the name, date and signature on the application.

TRANSITIONAL AND FINAL PROVISIONS

§1. The Policy for the Activity of BULSTRAD LIFE VIENNA INSURANCE GROUP JSC in relation to the Settlement of Claims regarding Insurance Contracts have been adopted on the grounds of Article 104 of the Insurance Code.
§2. The Policy for the Activity of BULSTRAD LIFE VIENNA INSURANCE GROUP JSC in relation to the Settlement of Claims regarding Insurance Contracts has been adopted by the Management Board of the Company by decision under Record No 23 dated 21 June 2006, amended and supplemented by decision under Record No 28 dated 1 September 2006, decision under Record No 102 dated 29 January 2013, effective since 1 February 2013, decision under Record No 139 dated 4 September 2014, effective since 15 September 2014, decision under Record No dated 21 July 2016, effective since 1 August 2016, decision under Record No 234 dated 29 May 2018, effective since 30 May 2018 and decision under Record No 278 dated 6 February 2020.

Appendix No 1
HEALTHCARE INSURANCE

Documents required when filing a claim for insurance payment

Application for payment of an insurance amount by the insured person or legal representative (in the form of the Insurer).

Reimbursement of expenses for examinations:
- Medical document with specified diagnosis, performed activities, prescribed tests and prescribed therapy, signature of the physician and the person insured, seal of the medical institution (copy or original);
- Original invoice (detailed) with fiscal receipt in the name of the person.

Reimbursement of expenses for tests:
- Medical document with specified diagnosis and prescribed examinations, signature of the physician and the person insured, seal of the medical institution (copy or original);
- Copy of the results from tests made;
- Original invoice (detailed) with fiscal receipt in the name of the person.

Reimbursement of expenses for medications:
- Medical document with specified diagnosis and prescribed therapy, signature of the physician and the person insured, seal of the medical institution (copy or original);
- Prescription for prescribed home treatment with specified quantity and dosage of the medications, as well as the term for being treated with them (copy or original). The prescription shall have a date of issue, signature and seal of the attending physician;
- Original invoice (detailed) with fiscal receipt in the name of the person.

Reimbursement of expenses for dioptre glasses/lenses:
- Medical document with specified diagnosis and prescribed therapy, signature of the physician and the person insured, seal of the medical institution (copy or original);
- Prescription with date of issue, signature and seal of the attending physician (copy or original);
- Stickers for purchased dioptre glasses/contact lenses
- Original invoice (detailed – dioptre glasses, frame and assembly) with fiscal receipt in the name of the person.

Reimbursement of expenses for hospital treatment, consumables and auxiliary means:
- Medical history from the medical institution with signature of the attending physician and seal;
- Declaration for choice of medical team;
- Prescription for auxiliary supplies and consumables;
- Stickers for input medical articles or other evidence certifying the input of a medical article issued/provided by the same medical institution that has performed the surgical intervention;
- Detailed bill from the hospital for the respective types of expenses;
- Original (detailed) invoice with fiscal receipt in the name of the person.

Reimbursement of expenses for surgery in ambulatory conditions:
- Medical document with description of the performed manipulation;
- Original (detailed) invoice with fiscal receipt in the name of the person.

Reimbursement of expenses for physiotherapeutic procedures:
- Medical document with procedures prescribed by a physician – speciality in physical and rehabilitation medicine;
- Physio Procedures Card;
- Original (detailed) invoice in the name of the person with entered number of procedures and single value of the procedure;
- Fiscal receipt.

Reimbursement of expenses for dental care
- Medical document with entered manipulations performed (upon first claim of documents for expenses, described full dental status);
- In the treatment of pulpitis and periodontitis and extraction preceding radiography;
- Original (detailed) invoice with fiscal receipt in the name of the person.

Appendix No 2
LIFE INSURANCE

Documents required when filing a claim for insurance payment

1.In the event of death:

- Application for payment of an insurance amount or a part thereof by the entitled person (in the form of the insurer) – original;
- Identity card of the User of Insurance Service – certified copy;
- Insurance policy and annexes (if any) – original;
- Transcript and extract of a Death Certificate;
- Death Notice from the physician confirming death – original or certified copy;
- Inheritance certificate if, as beneficiaries, they have not been indicated by name;
- Bank account certificate – original;
- Declaration under Article 42, Paragraph 2, Item 2 of the Measures Against Money Laundering Act in the form of the Insurer – original;
- Declaration for the purposes of automatic exchange of financial information on the grounds of Article 142r, Paragraph 1 of the Tax and Insurance Procedure Code.

2. In the event of permanent incapacitation:

- Application for payment of an insurance amount or a part thereof by the entitled person (in the form of the insurer) – original;
- Identity card of the User of Insurance Service – certified copy;
- Insurance policy and annexes (if any) – original;
- Decision of the Territorial Expert Medical Commission/National Expert Medical Commission certified by the Regional Health Inspection;
- Medical histories, outpatient sheets and other medical documents related to the insurance event;
- Bank account certificate – original;
- Declaration under Article 42, Paragraph 2, Item 2 of the Measures Against Money Laundering Act in the form of the Insurer – original;
- Declaration for the purposes of automatic exchange of financial information on the grounds of Article 142r, Paragraph 1 of the Tax and Insurance Procedure Code.

* Other documents certifying the date, cause and circumstances under which the insurance event occurred (for example: inquiry from the National Health Insurance Fund, statements by the Road Traffic Control Office, Personal Outpatient Card (POC), HD (history of the disease), outpatient sheets, medical histories, autopsy record, result of pre-trial proceedings, etc.)

3. In case of survival, full or partial redemption:

- Application for payment of an insurance amount (redemption value by the entitled person in the form of the insurer) – original;
- Identity card of the User of Insurance Service – certified copy;
- Insurance policy and annexes (if any) – original;
- A declaration certified at a notary's office that the insurant is alive at the moment of expiry of the insurance period, if he or she does not appear before the Insurer in person with an identity document;
- Bank account certificate – original;
- Declaration under Article 42, Paragraph 2, Item 2 of the Measures Against Money Laundering Act in the form of the Insurer – original
- Declaration for the purposes of automatic exchange of financial information on the grounds of Article 142r, Paragraph 1 of the Tax and Insurance Procedure Code;
- Declaration on the grounds of Article 65, Paragraph 8 of the Income Taxes on Natural Persons Act.

* Other documents if necessary.

Appendix No 3
INDIVIDUAL ACCIDENT INSURANCE AND INDIVIDUAL ILLNESS INSURANCE

Documents required when filing a claim for insurance payment

1. In the event of death:

- Application for payment of an insurance amount or a part thereof by the entitled person (in the form of the insurer) – original;
- Identity card of the User of Insurance Service – certified copy;
- Insurance policy – copy;
- Transcript and extract of a Death Certificate;
- Death Notice from the physician confirming death – original or certified copy;
- Inheritance certificate, official note – information in the form of the insurer (in the case of group policies concluded by the employer);
- Bank account certificate – original
- Declaration under Article 42, Paragraph 2, Item 2 of the Measures Against Money Laundering Act in the form of the insurer – original.

2. In the event of a permanently reduced or lost working capacity:

- Application for payment of an insurance amount or a part thereof by the entitled person (in the form of the insurer) – original;
- Identity card of the User of Insurance Service – certified copy;
- Insurance policy;
- Decision of the Territorial Expert Medical Commission/National Expert Medical Commission with a determined percentage of permanently reduced or lost working capacity;
- Medical documents related to the occurrence of the insurance event – outpatient sheets, medical histories, results of medical tests, etc.;
- Official note – information in the form of the Insurer (in the case of group policies concluded by the employer);
- Bank account certificate – original;
- Declaration under Article 42, Paragraph 2, Item 2 of the Measures Against Money Laundering Act in the form of the insurer – original.

3. In the event of temporary disablement:

- Application for payment of an insurance amount or a part thereof by the entitled person (in the form of the insurer) – original;
- Identity card of the User of Insurance Service – described in the Application Form of the Insurer, without taking a copy;
- Insurance policy;
- Inpatient sheets certifying a period of temporary disablement;
- Medical history(ies) (in the case of inpatient treatment);
- Official note – information in the form of the Insurer (in the case of group policies concluded by the employer);
- Bank account certificate – original;
- Declaration under Article 42, Paragraph 2, Item 2 of the Measures Against Money Laundering Act in the form of the insurer – original.

4. In the event of incurred medical expenses:

- Application for payment of an insurance amount or a part thereof by the entitled person (in the form of the insurer) – original;
- Identity card of the User of Insurance Service – described in the Application Form of the Insurer, without taking a copy;
- Insurance policy;
- Outpatient sheet from an examination;
- Prescriptions for prescribed medications;
- Invoices with fiscal receipts for expenses incurred – original;
- Medical history(ies) (in the case of inpatient treatment);
- Bank account certificate – original;
- Declaration under Article 42, Paragraph 2, Item 2 of the Measures Against Money Laundering Act in the form of the insurer – original.

* Other documents certifying the date, cause and circumstances under which the insurance event occurred (for example: inquiry from the National Health Insurance Fund, record from the MAC (Medical Advisory Committee), statements by the Road Traffic Control Office, Personal Outpatient Card (POC), HD (history of the disease), outpatient sheets, medical histories, result of pre-trial proceedings, etc.).

Appendix No 4
LONG TERM HEALTH INSURANCE

Documents required when filing a claim for insurance payment

1. In case of hospitalisation

- Application for payment of an insurance amount or a part thereof by the entitled person (in the form of the insurer) – original;
- Identity card of the User of Insurance Service – described in the Application Form of the Insurer, without taking a copy;
- Insurance policy and annexes (if any);
- Medical history(ies) from inpatient treatment;
- Bank account certificate – original;
- Declaration under Article 42, Paragraph 2, Item 2 of the Measures Against Money Laundering Act in the form of the insurer – original.

2. In the event of the insurant's visit to a physician after discharge from hospital

- Application for payment of an insurance amount or a part thereof by the entitled person (in the form of the insurer) – original;
- Insurance policy and annexes (if any);
- Outpatient sheet certifying an examination;
- Bank account certificate – original;
- Declaration under Article 42, Paragraph 2, Item 2 of the Measures Against Money Laundering Act in the form of the insurer – original.

* Other documents certifying the date, cause and circumstances under which the insurance event occurred (for example: inquiry from the National Health Insurance Fund, statements by the Road Traffic Control Office, HD (history of the disease), Personal Outpatient Card (POC), result of pre-trial proceedings, etc.)

Appendix No 5
CRITICAL ILLNESS INSURANCE

Documents required when filing a claim for insurance payment

- Application for payment of an insurance amount or a part thereof by the entitled person (in the form of the insurer) – original;
- Identity card of the User of Insurance Service – described in the Application Form of the Insurer, without taking a copy;
- Insurance policy and annexes (if any) – original;
- Medical history(ies) from hospital treatment;
- Bank account certificate – original;
- Declaration under Article 42, Paragraph 2, Item 2 of the Measures Against Money Laundering Act in the form of the insurer – original.

* Other documents certifying the date, cause and circumstances under which the insurance event occurred (for example: inquiry from the National Health Insurance Fund, HD (history of the disease), Personal Outpatient Card (POC), outpatient sheets, result of pre-trial proceedings, etc.)

Appendix No 6
COMPLEX HEALTH INSURANCE

Documents required when filing a claim for insurance payment

1. In the case of hospitalisation/surgery costs

- Application for payment of an insurance amount or a part thereof by the entitled person (in the form of the insurer – original);
- Identity card of the User of Insurance Service – described in the Application Form of the Insurer, without taking a copy;
- Insurance policy and annexes (if any);
- Medical history(ies) from inpatient treatment;
- Bank account certificate – original;
- Declaration under Article 42, Paragraph 2, Item 2 of the Measures Against Money Laundering Act in the form of the insurer – original.

2. Expenses for medicines, medical devices and use of medical devices

- Application for payment of an insurance amount or a part thereof by the entitled person (in the form of the insurer – original);
- Identity card of the User of Insurance Service – described in the Application Form of the Insurer, without taking a copy;
- Insurance policy and annexes (if any);
- Medical history from inpatient treatment;
- Inpatient sheet certifying a period of temporary disablement;
- Prescriptions for prescribed medications;
- Invoices with fiscal receipts for purchased medicines – original;
- Bank account certificate – original;
- Declaration under Article 42, Paragraph 2, Item 2 of the Measures Against Money Laundering Act in the form of the insurer – original.

* Other documents certifying the date, cause and circumstances under which the insurance event occurred (for example: inquiry from the National Health Insurance Fund, record from the MAC (Medical Advisory Committee), statements by the Road Traffic Control Office, Personal Outpatient Card (POC), HD (history of the disease), outpatient sheets, result of pre-trial proceedings, etc.).

Appendix No 7
CHILD RISK INSURANCE

Documents required when filing a claim for insurance payment

- Application for payment of an insurance amount or a part thereof by the entitled person (in the form of the insurer) – original;
- dentity card of the User of Insurance Service – described in the Application Form of the Insurer, without taking a copy;
- Insurance policy and annexes (if any);
- Medical histories from inpatient treatment;
- Bank account certificate – original;
- Declaration under Article 42, Paragraph 2, Item 2 of the Measures Against Money Laundering Act in the form of the insurer – original.

* Other documents certifying the date, cause and circumstances under which the insurance event occurred (for example: inquiry from the National Health Insurance Fund, statements by the Road Traffic Control Office, Personal Outpatient Card (POC), HD (history of the disease), outpatient sheets, result of pre-trial proceedings, etc.)

Appendix No 8
LIFE RISK INSURANCE

Documents required when filing a claim for insurance payment

1. Documents required in the event of death

- Application for payment of an insurance amount or a part thereof by the entitled person (in the form of the insurer) – original;
- Official note – information from the employer about the occurrence of an insurance event in the form of the Insurer (only in the case of group insurance made at the expense of the employer) – original;
- Identity card of the User of Insurance Service – described in the Application Form of the Insurer, without taking a copy;
- Insurance policy;
- Transcript and extract of a Death Certificate;
- Death Notice from the physician confirming death – original or certified copy;
- Inheritance certificate if, as beneficiaries, they have not been indicated by name;
- Bank account certificate – original;
- Declaration under Article 42, Paragraph 2, Item 2 of the Measures Against Money Laundering Act in the form of the insurer – original.

2. Documents required in the event of a permanently reduced or lost working capacity

- Application for payment of an insurance amount or a part thereof by the entitled person (in the form of the insurer) – original;
- Identity card of the User of Insurance Service – described in the Application Form of the Insurer, without taking a copy;
- Official note – information from the employer about the occurrence of an insurance event in the form of the Insurer (only in the case of group insurance made at the expense of the employer) – original;
- Insurance policy;
- Decision of the Territorial Expert Medical Commission/National Expert Medical Commission with a determined percentage of lost working capacity – certified by the Regional Health Inspection;
- Bank account certificate – original;
- Declaration under Article 42, Paragraph 2, Item 2 of the Measures Against Money Laundering Act in the form of the insurer – original.

3. Documents required in the event of temporary loss of working capacity

- Application for payment of an insurance amount or a part thereof by the entitled person (in the form of the insurer);
- Identity card of the User of Insurance Service – described in the Application Form of the Insurer, without taking a copy;
- Official note – information from the employer about the occurrence of an insurance event in the form of the Insurer (only in the case of group insurance made at the expense of the employer) – original;
- Insurance policy;
- Inpatient sheets certifying the duration of temporary disablement;
- Bank account certificate – original;
- Declaration under Article 42, Paragraph 2, Item 2 of the Measures Against Money Laundering Act in the form of the insurer – original.

* Other documents certifying the date, cause and circumstances under which the insurance event occurred (for example: an inquiry from the National Health Insurance Fund, record from the MAC (Medical Advisory Committee), statements by the Road Traffic Control Office, Personal Outpatient Card (POC), HD (history of the disease), outpatient sheets, medical histories, result of pre-trial proceedings, etc.)

Appendix No 9
TRAVELLER'S INSURANCE

Documents required when filing a claim for insurance payment

- Application for payment of an insurance amount or a part thereof by the entitled person (in the form of the insurer) – original;
- Identity document of the User of Insurance Service – described in the Application Form of the insurer, without taking a copy;
- Insurance policy;
- Medical report certifying an examination or inpatient treatment;
- Prescriptions for prescribed medications;
- Invoice/s certifying expenses incurred – original;
- Bank account certificate – original.

* Other documents certifying the date, cause and circumstances under which the insurance event occurred (for example: police report, inquiry from the National Health Insurance Fund, etc.)

*All documents other than English or Bulgarian shall be provided with an official translation.

Appendix No 10
FOREIGNERS RESIDING IN THE REPUBLIC OF BULGARIA FOR A SHORT PERIOD OR A LONG PERIOD OR TRANSITTING THE COUNTRY

Documents required when filing a claim for insurance payment

- Application for payment of an insurance amount or a part thereof by the entitled person (in the form of the insurer) – original;
- Identity document of the User of Insurance Service – described in the Application Form of the insurer, without taking a copy;
- Insurance policy;
- Outpatient sheet from an examination;
- Medical history from inpatient treatment;
- Prescriptions for prescribed medications;
- Results from tests made;
- Invoices with fiscal receipts for medical expenditures incurred – original;
- Bank account certificate – original.

* Other documents certifying the date, cause and circumstances under which the insurance event occurred (for example: statements by the Road Traffic Control Office, HD (history of the disease), result of pre-trial proceedings, etc.)

Appendix No 11
INDIVIDUAL HEALTH INSURANCE „PREMIUM“

Documents required when filing a claim for insurance payment

- Application for payment of an insurance amount by the insured person (in the form of the insurer);
- Insurance policy – copy;
- Declaration under Article 42, Paragraph 2, Item 2 of the Measures Against Money Laundering Act in the form of the insurer – original.

Reimbursement of expenses for examinations:
- Outpatient sheet with specified diagnosis, performed activities, prescribed tests and prescribed therapy, signature of the physician and the person insured, seal of the medical institution (copy or original);
- Original invoice (detailed) with fiscal receipt in the name of the person.

Reimbursement of expenses for tests:
- Outpatient sheet with specified diagnosis and prescribed examinations, signature of the physician and the person insured, seal of the medical institution (copy or original);
- Copy of the results from tests made;
- Original invoice (detailed) with fiscal receipt in the name of the person.

Reimbursement of expenses for medications:
- Outpatient sheet with specified diagnosis and prescribed therapy, signature of the physician and the person insured, seal of the medical institution (copy or original);
- Prescription for prescribed home treatment with specified quantity and dosage of the medications, as well as the term for being treated with them (copy or original). The prescription shall have a date of issue, signature and seal of the attending physician;
- Original invoice (detailed) with fiscal receipt in the name of the person.

Reimbursement of expenses for dioptre glasses/lenses:
- Outpatient sheet with specified diagnosis and prescribed therapy, signature of the physician and the person insured, seal of the medical institution (copy or original);
- Prescription with date of issue, signature and seal of the attending physician (copy or original);
- Stickers for purchased dioptre glasses/contact lenses;
- Original invoice (detailed – dioptre glasses, frame and assembly) with fiscal receipt in the name of the person.

Reimbursement of expenses for hospital treatment, consumables and auxiliary means:
- Medical history from the medical institution with signature of the attending physician and seal;
- Declaration for choice of medical team;
- Prescription for auxiliary supplies and consumables;
- Stickers for input medical articles or other evidence certifying the input of a medical article issued/provided by the same medical institution that has performed the surgical intervention;
- Detailed bill from the hospital for the respective types of expenses;
- Original (detailed) invoice with fiscal receipt in the name of the person.

Reimbursement of expenses for surgery in ambulatory conditions:
- Medical document with description of the performed manipulation;
- Original (detailed) invoice with fiscal receipt in the name of the person.

Reimbursement of expenses for physiotherapeutic procedures:
- Medical document with procedures prescribed by a physician – speciality in physical and rehabilitation medicine;
- Physio Procedures Card;
- Original (detailed) invoice in the name of the person with entered number of procedures and single value of the procedure;
- Fiscal receipt.

Reimbursement of expenses for dental care:
- Medical document with entered manipulations performed (upon first claim of documents for expenses, described full dental status);
- In the treatment of pulpitis and periodontitis and extraction preceding radiography;
- Original (detailed) invoice with fiscal receipt in the name of the person.

Appendix No 12
SHORT TERM CORPORATE HEALTH INSURANCE

Documents required when filing a claim for insurance payment

- Application for payment of an insurance amount or a part thereof by the entitled person (in the form of the insurer) – original;
- Identity document of the User of Insurance Service – described in the Application Form of the insurer, without taking a copy;
- Official note – information from the employer for the occurrence of an insurance event in the form of the insurer (only in the case of group insurance made at the expense of the employer) – original;
- Insurance policy;
- In the event of hospital treatment – medical history, original invoices issued by a hospital;
- In the event of outpatient treatment – outpatient sheets, results of tests, prescriptions for prescribed medications, original invoices with fiscal receipts for expenses incurred;
- Bank account certificate – original;
- Declaration under Article 42, Paragraph 2, Item 2 of the Measures Against Money Laundering Act in the form of the insurer – original.

* Other documents certifying the date, cause and circumstances under which the insurance event occurred (for example: an inquiry from the National Health Insurance Fund, record from the MAC (Medical Advisory Committee), statements by the Road Traffic Control Office, Personal Outpatient Card (POC), HD (history of the disease), outpatient sheets, medical histories, result of pre-trial proceedings, etc.)