I. GENERAL PROVISIONS

Article 1. These rules govern the procedures under which SOLELY OWNED JOINT STOCK COMPANY (ZEAD) BULSTRAD LIFE VIENNA INSURANCE GROUP EAD accepts insurance claims, collects evidence to confirm their grounds and amount, determines the amount of insurance payments, makes payments with users of insurance services and handles complaints in connection with such claims.

Article 2. The rules for the activity of SOLELY OWNED JOINT STOCK COMPANY (ZEAD) BULSTRAD LIFE VIENNA INSURANCE GROUP EAD in settling insurance claims are prepared in accordance with the Insurance Code, the Measures Against Money Laundering Act, Personal Income Tax Act, the Corporate Income Tax Act and the General Terms and Conditions of the insurances offered by the Insurer.

Article 3. Hereinafter the „Rules for the activity of SOLELY OWNED JOINT STOCK COMPANY (ZEAD) BULSTRAD LIFE VIENNA INSURANCE GROUP EAD in settlement of insurance claims" shall be referred to as the "Rules"; the persons filing claims shall be referred to as the „Users of insurance services", and SOLELY OWNED JOINT STOCK COMPANY (ZEAD) BULSTRAD LIFE VIENNA INSURANCE GROUP EAD shall be referred to as the „Insurer".

Article 4. The term „Insurance amount" shall mean one of the following:

1) Insurance amount in case of survival, death or permanently reduced or lost ability of the Insured;

2) part of the Insurance amount in case of temporary, permanently reduced or lost ability of the Insured or indemnity for medical expenses incurred by the Insured, or redemption of the contract;

3) insurance payment in case of hospitalization, medical expenses, temporary loss of ability, annuity payments, etc., according to the terms of the insurance policy.

Article 5. The necessary documents for filing insurance claims are listed in Appendices 1 to 9, which are an integral part of these Rules.

II. HANDLING OF CLAIMS

Article 6. The claim filed at the Central office of the Insurer, at the agencies or offices of the Company, and at the partners of the Insurer in writing, by filling out an Application form of the Insurer (electronic or on paper) by the User of insurance services, by its legal heir or representative, or by the beneficiary under the insurance. If the rightful claimant is a minor or incapable person, the claim shall be submitted by his/her legal representative, who has proved its capacity with the respective document.

Article 7. The Application under Article 6 is available on the official website of the Insurer: https://www.bulstradlife.bg/customer-service/applications. It is a mandatory document when filing a claim for payment of the insurance amount under the contract, and can be submitted every working day from 9:00 a.m. to 5:30 p.m. at the offices of the Insurer by courier or electronically in the form of the Insurer, where such is provided for. If the customer is insured under more than one insurance contract, under which the customer wishes to file a claim, the customer fills out separate Applications for each insurance contract.

Article 8. If the User of the insurance service wishes to receive communication about the insurance claim electronically, the Application shall contain names, address for correspondence and electronic address.

Article 9. 1) Upon receipt of a claim for payment of Insurance amount, depending on the Insured event, the Insurer verifies the filled out data in the application and the documents submitted by the applicant. If necessary, the Insurer requires from the User of the insurance service or its legal representatives or heirs additional data and documents according to the respective Appendix, which is a part of these Rules.

2) If in order to clarify the reasons and the circumstances of the occurrence of the insurance event, a special investigation and submission of further evidence is needed, which was not provided for in the insurance contract upon its conclusion and which is necessary for establishing the grounds and the amount of the claim, the Insurer informs the beneficiaries under the insurance contract about such further evidence at latest within 45 (forty-five) days after the submission of the evidence determined in the insurance contract and these Rules.

3) The Insurer shall notify the User of the insurance service in writing about all additional documents necessary to confirm in an indisputable manner the grounds and the amount of the claim, at the address specified by the user when filing the claim.

Article 10. Where the Insurer directly requests additional information from judicial institutions, trusted physicians, hospitals, investigating authorities, employers, etc., the Insurer notifies the beneficiary in writing about the requested information.

Article 11. The receipt of the initially and further submitted evidence is certified by the Insurer with an incoming number and date. The documents submitted for each insurance claim form the claim file.

Article 12. 1) The documents under Appendices 1 to 12 must be submitted in original, and if it is objectively impossible to submit them in original, they are submitted in the form of notarized copies.

2) In case a document is issued in a foreign language, it is submitted to the Insurer as a translation into Bulgarian made by a sworn translator.

3) The Insurer may accept copies of documents at its discretion.

Article 13. After the documents are received at the Central office of the Insurer, they are sent to the Claims department. Depending on the specifics of the particular type of insurance, the claims may be handled by Life Insurance Claim Handling or Health Insurance Claim Handling.

Article 14. Each insurance claim is registered in the information system of the Company and receives a unique number. All documents related to the claim and received in and sent by the Company constitute the insurance file.

Article 15. 1) Each insurance claim is reviewed and handled by an employee of the Claims department, who enters the data into the information system of the Company, reviews the submitted information in the file, makes a assessment of the claim based on the available documentation related to the insurance event, checks the status of the insurance policy in the information system, checks the terms and conditions of the concluded insurance contract and assesses the need for further evidence.

2) Any claim requiring an additional medical opinion in accordance with the amount of the Insurance amount must be consulted with a trusted physician of the Insurer, who issues a written, motivated opinion on the case. If the trusted physician considers that the submitted documents are incomplete or insufficient to clarify the claim, he/she may recommend in writing that additional documents are required. The written opinion of the trusted physician becomes part of the insurance file.

3) Depending on the nature and complexity of the claim, it can also be consulted with an expert of the Legal department, an actuary, a financial and accounting expert or an external expert in the listed fields, with whom the Company has a signed contract. In such cases, the written opinion of the respective expert becomes part of the insurance file.

Article 16. The expert of the Claims department pronounces on the file as follows: with an „insurance claim report", in the case where a decision has been made for full or partial payment of an Insurance amount or insurance indemnity, or with an "opinion on the case" in the case where the claim is rejected. In the latter case, the expert mandatory sends a justification of such decision.

Article 17. The determination of the amount of taxes, fees, etc., which exist or will be levied on the amount of the insurance payment, is carried out in compliance with internal procedures prepared in accordance with the requirements of the Bulgarian law.

Article 18. Based on the prepared Insurance claim report, the Accounting department makes the payment to the bank account provided by the beneficiary. The bank account must be in a bank operating on the territory of the Republic of Bulgaria or the European Union.

Article 19. 1) The Insurance amount under the insurance claim is determined according to the terms and conditions of the insurance contract and is payable by the Insurer to the persons specified in the insurance policy or to the beneficiaries provided by law.

2) Payment by the Insurer to User of insurance services through third parties is allowed only on the basis of an explicit written power of attorney with notarized signatures for the respective insurance claim or through payment containing a statement that the User of insurance services is informed about its right to receive the payment in person to a bank account. If the third party is an insurance broker, the payment under the insurance claim is made only to the customer account of the person.

Article 20. The Policy holder can receive a redemption price from the Insurer in case of early termination of the insurance.

1) The Policy holder has the right to receive a redemption price, provided that at least two full insurance years have elapsed from the beginning of the insurance coverage and the premiums have been paid according to the terms and conditions, and in the amount specified in the insurance contract. The requirement that at least two years have passed does not apply where 15 percent or more of the insurance premiums have been paid. The amount of the redemption price is defined in the General Terms and Conditions of the insurance.

2) The entitled person makes a claim for the payment of a redemption price by submitting an application for redemption. The application for redemption is accepted by the Insurer with affixed incoming number and date, and the redemption price is calculated by this date (the date of the application for redemption). Payment of the redemption value is made to the bank account provided by the person entitled to receive the redemption price.

III. CLAIMS CLASSIFICATION

Article 21. 1) After being registered in the information system, the claim is classified in one of the following sections:

1. „Not handled" section – includes every claim registered in the information system that has not yet been evaluated by an expert claim handler.
2. „Paid claims" section – includes all claims for which payment of an insurance amount has been made, if all terms and conditions of the insurance contract are fulfilled, the submitted documents indisputably prove the amount and the grounds of the claim and the conditions of these Rules are met.
3. „Suspended claims" section – includes all claims on which a decision to make a payment or to justify a refusal on the claim cannot be made due to a lack of information confirming their grounds and/or amount. These files reflect any further information requested. The Insurer is obliged to inform the User of the insurance services in writing about any further information and evidence to be submitted, describing in detail in written correspondence the type of this information (for example: questionnaire; epicrisis, personal outpatient card, report of the Traffic Police, etc.). No later than 6 (six) months from the date of filing the claim, regardless of whether the beneficiary has provided the requested information, the Insurer is obliged to make a decision to pay the insurance indemnity or to justify in writing the refusal to make the payment.
4. „Rejected claims" section – this category reflects the damages for which the Insurer has decided to reject the claim giving the beneficiary a written justification.
5. „Withdrawn claims" section – this category includes the cases where the person entitled to receive an Insurance amount or indemnity has given up or withdrawn its application in writing.
6. „Expired claims" section - this category includes the cases with expired limitation period according to the Insurance code.

2) In case of refusal to pay the claimed insurance payment, the Insurer is obliged to send the User of insurance services a justified response.

Article 22. (1) The insurance amount or the respective part thereof is paid only by bank transfer within 15 (fifteen) business days from the date of submission of all required documents to the Insurer, which is proven by the incoming number according to the inventory of the Company.

IV. HANDLING OF COMPLAINTS

Article 23. For the purposes of these Rules, „complaint" means a written complaint regardless of how it is titled, which expresses dissatisfaction or disagreement of the User of insurance services with the services provided by the Insurer, including decisions on claims handling files and complaints/disagreements from/with the behaviour of employees, insurance brokers or other persons working on behalf of the Company.

Article 24. 1) If the beneficiary does not agree with the refusal or with the amount of the insurance payment, the beneficiary may submit a written complaint, in which the objections are stated and further evidence supporting such objections is given. For the manner of filing a complaint, Article 6 of these Rules applies.

2) Any person may file a complaint and recommendation in any of the following ways:

1. personally at any office of SOLELY OWNED JOINT STOCK COMPANY (ZEAD) BULSTRAD LIFE VIENNA INSURANCE GROUP EAD, as well as at the Central office: Sofia 1301, 6, Sveta Sofia Street;
2. by email at:

2.1. bullife@bulstradlife.bg, lifeclaims@bulstradlife.bg, support@bulstradlife.bg – for all users of insurance services;

2.2. md@bulstradlife.bg, healthclaims@bulstradlife.bg – for customers with "Healthcare" insurance;

3. through the form on the website of the Company at: www.bulstradlife.bg;

3) In all cases where the sender must be identified, the sender must give consent for use and processing of personal data according to the provisions of the Personal Data Protection Act, as well as consent to disclosure of insurance secret according to the provisions of the Insurance Code.

4) The official language in which complaints, inquiries, signals and recommendations are submitted is Bulgarian. Documents submitted in a foreign language must be accompanied by an accurate translation into Bulgarian.

5) Complaints submitted anonymously and whose sender cannot be identified will not be handled.

Article 25. The Insurer maintains a register of received complaints. All written complaints received at SOLELY OWNED JOINT STOCK COMPANY (ZEAD) BULSTRAD LIFE VIENNA INSURANCE GROUP EAD are registered on the day they are received, if are received within the working hours of the Company, and in all other cases – on the next working day, and are distributed according to competence to the respective responsible unit of the Company.

Article 26. The complaint is submitted to the Insurer in free text, and must necessarily contain at least the following details:

1. description of the objection and formulation of the request (in case of complaint); description of the inquiry; description of the identified irregularity or description of the identified weakness and recommendation for its improvement;
2. insurance policy number (ID card number for customers with health care insurance) or insurance claim number, if applicable;
3. details of the submitting person, as follows:
3.1. for local natural persons - three names and personal identification number (PIN);
3.2. for foreign natural persons - names, personal number/NRA or data from another valid analogous document
3.3. for legal entities - name of the legal entity, Unified Identification Code (UIC), information about its managers and representatives;
4. signed Privacy Notice according to the requirements of Regulation (EU) 2016/679 of the European Parliament;
5. address for correspondence (postal and/or electronic) and contact telephone number;
6. list of attached documents, if any;
7. signature of the person filing the complaint or of his legal representative or proxy, if submitted on paper.

Article 27. 1) Upon receipt of a complaint concerning a claim at the Central office of the Insurer, it is sent to the Claims department. The relevant expert gets acquainted with the reasons for the complaint and within 7 (seven) working days prepares a written response justifying legally and factually the determined amount of the insurance payment. Where the complaint is against a complete refusal by the Insurer concerning the grounds of the claim, the deadline for ruling is 30 days from the date of its receipt.

2) Where the case is of high legal and factual complexity, the response to the complaint is agreed with a legal counsel. Where the complaint concerns issues requiring an expert opinion from a physician or another person, the answer is agreed with the relevant expert.

3) If the complaint is filed through the Financial Supervision Commission (FSC), the Insurer rules within the deadlines indicated in the inquiry by the FSC. If the initial decision on a complaint filed through the FSC is changed, the Insurer notifies both the Commission and the complainant in writing.

V. CONFIDENTIALITY IN SETTLEMENT OF INSURANCE CLAIMS

Article 28. Settlement of insurance claims at SOLELY OWNED JOINT STOCK COMPANY (ZEAD) BULSTRAD LIFE VIENNA INSURANCE GROUP EAD is carried out in accordance with the internal privacy rules adopted by the Company available on the website of the Company at: www.bulstradlife.bg.

Article 29. Personal data processing during the proceedings for insurance claims settlement, including the health data of the User of the insurance services, is carried out without the need for explicit consent. Data is processed solely for the purposes of insurance claims settlement and fulfilment of the obligations under the insurance contract, and exclusively in the interest of the Users of insurance services in order that the Insurer decided on the submitted claim.

Article 30. When filing an insurance claim, the User of the insurance services familiarizes itself with and accepts the Privacy Notice, which becomes an integral part of the insurance file.

Article 31. The Privacy Notice is available on the website of the Insurer: https://www.bulstradlife.bg/customer-service/applications, while in cases where the person sends the application and the insurance claim documents by mail or by courier, the person must familiarize itself with the full text of the Privacy Notice available on the website of the Insurer and must confirm this by placing a name, date and signature on the application.

FINAL AND TRANSITIONAL PROVISIONS

§1. The rules for the activity of SOLELY OWNED JOINT STOCK COMPANY (ZEAD) BULSTRAD LIFE VIENNA INSURANCE GROUP EAD for the settlement of claims under insurance contracts were adopted on the grounds of Article 104 of the Insurance Code.

§2. The rules for the activity of SOLELY OWNED JOINT STOCK COMPANY (ZEAD) BULSTRAD LIFE VIENNA INSURANCE GROUP EAD for the settlement of claims under insurance contracts were adopted by the Management Board of the Company by decision under MoM No. 23 of 21.06.2006 amended and supplemented by decision under MoM No. 28 of 01/09/2006, decision under MoM No. 102 of 29/01/2013 effective from 01/02/2013, decision under MoM No. 139 of 04/09/2014 effective from 15/09/2014, decision under MoM No. of 21.07.2016, effective from 01.08.2016, decision under MoM No. 234 of 29.05.2018 effective from 30.05.2018 and decision under MoM No. 278 of 06.02.2020 effective from 05.05.2023 and decision under MoM No. 364 of 05.04.2023.

Appendix 1
„HEALTHCARE“ INSURANCE

Required documents for claiming an insurance payment

1. Application for payment of an insurance amount by the Insured or its legal representative (template of the Insurer)
2. Reimbursement of expenses for examinations;
3. Medical document with reflected diagnosis, performed activities, prescribed examinations and therapy, signature of the physician and of the Insured, stamp of the medical facility (copy or original);
4. Original invoice (detailed) with fiscal receipt in the name of the person.
5. Reimbursement of expenses for examinations:
6. Medical document with reflected diagnosis and prescribed examinations, signature of the physician and of the Insured, stamp of the medical facility (copy or original);
7. Copy of the results of the tests;
8. Original invoice (detailed) with fiscal receipt in the name of the person.
9. Reimbursement of expenses for medicines:
10. Medical document with reflected diagnosis and prescribed therapy, signature of the physician and of the Insured, stamp of the medical facility (copy or original);
11. Prescription for prescribed home treatment with indicated amount and dosage of the medicines, as well as the period for the treatment with them (copy or original). The prescription must have date of issue, signature and stamp of the attending physician;
12. Original invoice (detailed) with fiscal receipt in the name of the person.
13. Reimbursement of expenses for prescription spectacles/contact lenses:
14. Medical document with reflected diagnosis and prescribed therapy, signature of the physician and of the Insured, stamp of the medical facility (copy or original);
15. The prescription must have date of issue, signature and stamp of the attending physician (copy or original);
16. Stickers for purchased prescription spectacles/contact lenses;
17. Original invoice (detailed – prescription spectacles, frame and assembly) with fiscal receipt in the name of the person.
18. 1. Reimbursement of expenses for hospital treatment, consumables and medical devices:
19. Epicrisis from the medical facility with signature of the attending physician and stamp;
20. Declaration for selection of team;
21. Prescription for consumables and medical devices;
22. Stickers for implanted medical devices or other evidence certifying the implanting of the medical device issued/provided by the same medical facility performing the surgery;
23. Detailed bill from the hospital for the types of expenses;
24. Original invoice (detailed) with fiscal receipt in the name of the person.
25. Reimbursement of expenses for outpatient surgery:
26. Medical document with a description of the performed manipulation;
27. Original invoice (detailed) with fiscal receipt in the name of the person.
28. Reimbursement of expenses for physical therapy procedures:
29. Medical document for the procedures prescribed by a physician - specialist in physical and rehabilitation medicine;
30. Physical therapy card;
31. Original invoice (detailed) with listed number of procedures and unit price per procedure, issued to the Insured.
32. Fiscal receipt.
33. Reimbursement of expenses for dental care
34. Medical document reflecting the manipulations (upon the first application for reimbursement of expenses, complete description of the dental status);
35. For the treatment of pulpitis and periodontitis and extraction with preceding radiography;
36. Original invoice (detailed) with fiscal receipt in the name of the person.

Appendix 2
„LIFE“ INSURANCE

Required documents for claiming an insurance payment

I. In case of death:

1. Application for payment of an insurance amount or part thereof by the beneficiary (template of the Insurer) - original;

2. Personally certified with signature and date copy of the identity document of the beneficiary and the legal representative or other representative under power of attorney of the User of the insurance service - certified copy;

3. Insurance policy and addenda (if any) - original;

4. Excerpt of a Death certificate;

5. Notice for death by the physician who has ascertained the death - original or certified copy;

6. Certificate of heirs if they are not named as beneficiaries;

7. Certificate of a bank account - original;

8. Statement under Article 42, paragraph 2, item 2 of the Measures Against Money Laundering Act - template of the Insurer - original;

9. Declaration for the purposes of the automatic exchange of financial information on the grounds of Article 149s, Para. 1 of the Tax and Social Security Procedure Code.

II. In case of permanent loss of ability:

1. Application for payment of an insurance amount or part thereof by the beneficiary (template of the Insurer) - original;

2. Personally certified with signature and date copy of the identity document of the beneficiary and the legal representative or other representative under power of attorney of the User of the insurance service - certified copy;

3. Insurance policy and addenda (if any) - original;

4. LEMC/NEMC decision certified by the Regional Health Inspectorate as “effective”;

5. Epicrises, outpatient sheets and other medical documents related to the insurance event;

6. Certificate of a personal bank account - original;

7. Statement under Article 42, paragraph 2, item 2 of the Measures Against Money Laundering Act - template of the Insurer - original;

8. Declaration for the purposes of the automatic exchange of financial information on the grounds of Article 149s, Para. 1 of the Tax and Social Security Procedure Code.

* Other documents confirming the date, the cause and the circumstances of occurrence of the insurance event (for example: report from the National Health Insurance Fund, report from the Traffic Police, personal outpatient card /POC/, HD (history of the disease), outpatient sheets, epicrises, autopsy report, result of pre-trial proceedings, etc.)

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

1. Application for payment of an insurance amount or part thereof (redemption price) by the beneficiary (template of the Insurer) - original;

2. Personally certified with signature and date copy of the identity document of the beneficiary and the legal representative or other representative under power of attorney of the User of the insurance service - certified copy;

3. Insurance policy and addenda (if any) - original / or declaration of lost policy if no original is provided;

4. In case of survival - Notarized statement by the insured that he is alive by the expiration of the insurance period, if the Insured does not appear personally with an identity document before the Insurer;

5. Certificate of a personal bank account - original;

6. Statement under Article 42, paragraph 2, item 2 of the Measures Against Money Laundering Act - template of the Insurer - original;

7. Declaration for the purposes of the automatic exchange of financial information on the grounds of Article 149s, Para. 1 of the Tax and Social Security Procedure Code.

8. Statement on the grounds of Article 65, paragraph 8 of the Physical Persons Income Tax Act.

* Other documents, if required.

Appendix 3
PERSONAL „ACCIDENT“ AND “ILLNESS” INSURANCE

Required documents for claiming an insurance payment

I. In case of death:

1. Application for payment of an insurance amount or part thereof by the beneficiary (template of the Insurer) - original;

2. Copy of the identity document of the beneficiary and the legal representative or other representative under power of attorney of the User of the insurance service - certified copy;

3. Insurance policy -copy;

4. Excerpt of a Death certificate;

5. Notice for death by the physician who has ascertained the death - original or certified copy;

6. Certificate of heirs, official note - information from the employer - template of the Insurer (for group insurances concluded by the employer);

7. Certificate of a personal bank account - original;

8. Statement under Article 42, paragraph 2, item 2 of the Measures Against Money Laundering Act - template of the Insurer - original;

II. 2. In case of permanently reduced or lost ability:

1. Application for payment of an insurance amount or part thereof by the beneficiary (template of the Insurer) - original;

2. Personally certified with signature and date copy of the identity document of the beneficiary and the legal representative or other representative under power of attorney of the User of the insurance service - certified copy;

3. Insurance policy;

4. LEMC/NEMC decision with determined percentage of permanently reduced or lost ability certified by the Regional Health Inspectorate as “effective”;

5. Medical documents related to the Insured event, such as epicrises, outpatient sheets, results of tests, etc.;

6. Official note - information from the employer - template of the Insurer (for group insurances concluded by the employer);

7. Certificate of a personal bank account - original;

8. Statement under Article 42, paragraph 2, item 2 of the Measures Against Money Laundering Act - template of the Insurer - original;

III. In case of temporary disability:

1. Application for payment of an insurance amount or part thereof by the beneficiary (template of the Insurer) - original;

2. Personally certified with signature and date copy of the identity document of the beneficiary and the legal representative or other representative under power of attorney of the User of the insurance service - described in the Application (template of the Insurer), without taking a copy;

3. Insurance policy -copy;

4. Sick leave notes certifying the period of temporary inability;

5. Epicrisis/es (in case of hospital treatment);

6. Official note - information from the employer - template of the Insurer (for group insurances concluded by the employer);

7. Certificate of a personal bank account - original;

8. Statement under Article 42, paragraph 2, item 2 of the Measures Against Money Laundering Act - template of the Insurer - original;

IV. In case of incurred medical expenses:

1. Application for payment of an insurance amount or part thereof by the beneficiary (template of the Insurer) - original;

2. Copy of the identity document of the beneficiary and the legal representative or other representative under power of attorney of the User of the insurance service

3. Insurance policy;

4. Outpatient sheet from the performed examination;

5. Prescriptions for medicines;

6. Invoices with fiscal receipts for incurred expenses - original;

7. Epicrisis/es (in case of hospital treatment);

8. Certificate of a personal bank account - original;

9. Statement under Article 42, paragraph 2, item 2 of the Measures Against Money Laundering Act - template of the Insurer - original;

* Other documents confirming the date, the cause and the circumstances of occurrence of the insurance event (for example: report from the National Health Insurance Fund, report from the MCC (Medical Consulting Commission), report from the Traffic Police, personal outpatient card (POC), HD (history of the disease), outpatient sheets, epicrises, result of pre-trial proceedings, etc.

Appendix 4
LONG-TERM HEALTH INSURANCE

Required documents for claiming an insurance payment

1. Application for payment of an insurance amount or part thereof by the beneficiary (template of the Insurer) - original;
2. Personally certified with signature and date copy of the identity document of the beneficiary and the legal representative or other representative under power of attorney of the User of the insurance service
3. Insurance policy and addenda (if any);
4. Epicrisis/es from hospital treatment;
5. Certificate of a personal bank account - original;
6. Statement under Article 42, paragraph 2, item 2 of the Measures Against Money Laundering Act - template of the Insurer - original;
2. When the Insured visits a physician after discharge from hospital
7. Application for payment of an insurance amount or part thereof by the beneficiary (template of the Insurer) - original;
8. Insurance policy and addenda (if any);
9. Personally certified with signature and date copy of the identity document of the beneficiary and the legal representative or other representative under power of attorney of the User of the insurance service
10. Outpatient sheet confirming the performed examination;
11. Certificate of a personal bank account - original;
12. Statement under Article 42, paragraph 2, item 2 of the Measures Against Money Laundering Act - template of the Insurer - original;
* Other documents confirming the date, the cause and the circumstances of occurrence of the insurance event (for example: report from the National Health Insurance Fund, report from the Traffic Police, HD (history of the disease), personal outpatient card /POC/, result of pre-trial proceedings, etc.)

Appendix 5
„CRITICAL ILLNESS“ INSURANCE

Required documents for claiming an insurance payment

1. Application for payment of an insurance amount or part thereof by the beneficiary (template of the Insurer) - original;

2. Personally certified with signature and date copy of the identity document of the beneficiary and the legal representative or other representative under power of attorney of the User of the insurance service;

3. Insurance policy and addenda (if any) - original;

4. Epicrises from hospital treatment;

5. Certificate of a personal bank account - original;

6. Statement under Article 42, paragraph 2, item 2 of the Measures Against Money Laundering Act - template of the Insurer - original;

* Other documents confirming the date, the cause and the circumstances of occurrence of the insurance event (for example: report from the National Health Insurance Fund, HD (history of the disease), personal outpatient card (POC), result of pre-trial proceedings, etc.)

Appendix 6
„COMPLEX HEALTH INSURANCE“

Required documents for claiming an insurance payment

I. In case of hospitalization/expenses for surgical intervention

1. Application for payment of an insurance amount or part thereof by the beneficiary (template of the Insurer) - original;

2. Personally certified with signature and date copy of the identity document of the beneficiary and the legal representative or other representative under power of attorney of the User of the insurance service

3. Insurance policy and addenda (if any);

4. Epicrisis/es from hospital treatment;

5. Certificate of a personal bank account - original;

6. Statement under Article 42, paragraph 2, item 2 of the Measures Against Money Laundering Act - template of the Insurer - original;

II. Expenses for medications, medical devices and use of medical devices.

1. Application for payment of an insurance amount or part thereof by the beneficiary (template of the Insurer) - original;

2. Personally certified with signature and date copy of the identity document of the beneficiary and the legal representative or other representative under power of attorney of the User of the insurance service

3. Insurance policy and addenda (if any);

4. Epicrisis from hospital treatment;

5. Sick leave note certifying the period of temporary inability;

6. Prescriptions for medicines;

7. Invoices with fiscal receipts for purchased medicines - original;

8. Certificate of a personal bank account - original;

9. Statement under Article 42, paragraph 2, item 2 of the Measures Against Money Laundering Act - template of the Insurer - original;

* Other documents confirming the date, the cause and the circumstances of occurrence of the insurance event (for example: report from the National Health Insurance Fund, report from the MCC (Medical Consulting Commission), report from the Traffic Police, personal outpatient card (POC), HD (history of the disease), outpatient sheets, result of pre-trial proceedings, etc.

Appendix 7
„RISK CHILD INSURANCE“

Required documents for claiming an insurance payment

1. Application for payment of an insurance amount or part thereof by the beneficiary (template of the Insurer) - original;

2. Personally certified with signature and date copy of the identity document of the beneficiary and the legal representative or other representative under power of attorney of the User of the insurance service

3. Insurance policy and addenda (if any);

4. Epicrisis from hospital treatment;

5. Certificate of a personal bank account - original;

6. Statement under Article 42, paragraph 2, item 2 of the Measures Against Money Laundering Act - template of the Insurer - original;

* Other documents confirming the date, the cause and the circumstances of occurrence of the insurance event (for example: report from the National Health Insurance Fund, report from the Traffic Police, personal outpatient card /POC/, HD (history of the disease), outpatient sheets, result of pre-trial proceedings, etc.)

Appendix 8
RISK „LIFE“ INSURANCE

Required documents for claiming an insurance payment

I. Required documents in case of death

1. Application for payment of an insurance amount or part thereof by the beneficiary (template of the Insurer) - original;

2. Official note - information from the employer about occurrence of insurance event (only for group insurances concluded by the employer) -template of the Insurer - original;

3. Personally certified with signature and date copy of the identity document of the beneficiary and the legal representative or other representative under power of attorney of the User of the insurance service

4. Insurance policy -copy;

5. Excerpt of a Death certificate;

6. Notice for death by the physician who has ascertained the death - original or certified copy;

7. Certificate of heirs if they are not named as beneficiaries;

8. Certificate of a personal bank account - original;

9. Statement under Article 42, paragraph 2, item 2 of the Measures Against Money Laundering Act - template of the Insurer - original;

II. Required documents in case of permanently reduced or lost ability:

1. Application for payment of an insurance amount or part thereof by the beneficiary (template of the Insurer) - original;

2. Personally certified with signature and date copy of the identity document of the beneficiary and the legal representative or other representative under power of attorney of the User of the insurance service

3. Official note - information from the employer about occurrence of insurance event (only for group insurances concluded by the employer) -template of the Insurer - original;

4. Insurance policy;

5. LEMC/NEMC decision with determined percentage of lost ability certified by the Regional Health Inspectorate as “effective”;

6. Certificate of a personal bank account - original;

7. Statement under Article 42, paragraph 2, item 2 of the Measures Against Money Laundering Act - template of the Insurer - original;

III. Required documents in case of temporary lost ability:

1. Application for payment of an insurance amount or part thereof by the beneficiary (template of the Insurer);

2. Personally certified with signature and date copy of the identity document of the beneficiary and the legal representative or other representative under power of attorney of the User of the insurance service

3. Official note - information from the employer about occurrence of insurance event (only for group insurances concluded by the employer) -template of the Insurer - original;

4. Insurance policy -copy;

5. Sick leave notes certifying the period of temporary lost ability;

6. Certificate of a personal bank account - original;

7. Statement under Article 42, paragraph 2, item 2 of the Measures Against Money Laundering Act - template of the Insurer - original;

* Other documents confirming the date, the cause and the circumstances of occurrence of the insurance event (for example: report from the National Health Insurance Fund, report from the MCC (Medical Consulting Commission), report from the Traffic Police, personal outpatient card (POC), HD (history of the disease), outpatient sheets, epicrises, result of pre-trial proceedings, etc.)

Appendix 9
INSURANCE „TRAVELLING ABROAD“

Required documents for claiming an insurance payment

1. Application for payment of an insurance amount or part thereof by the beneficiary (template of the Insurer) - original;
2. Identity document of the User of the insurance services - described in the Application (template of the Insurer), without taking a copy;
3. Insurance policy;
4. Medical report confirming examination or hospital treatment;
5. Prescriptions for medicines;
6. Invoice/s confirming incurred expenses - original;
7. Certificate of a bank account - original.

* Other documents confirming the date, the cause and the circumstances of occurrence of the insurance event (for example: police report, report of the National Health Insurance Fund, etc.)

*All documents in languages other than Bulgarian are accompanied by an official translation.

Appendix 10
FOREIGNERS ON SHORT-TERM OR LONG-TERM STAY IN THE REPUBLIC OF BULGARIA OR TRANSITING THROUGH THE COUNTRY

Required documents for claiming an insurance payment

1. Application for payment of an insurance amount or part thereof by the beneficiary (template of the Insurer) - original;
2. Identity document of the User of the insurance services - described in the Application (template of the Insurer), without taking a copy;
3. Insurance policy;
4. Outpatient sheet from the performed examination;
5. Epicrisis from hospital treatment;
6. Prescriptions for medicines;
7. Results of tests;
8. Invoices with fiscal receipts for incurred medical expenses - original;
9. Certificate of a bank account - original.

* Other documents confirming the date, the cause and the circumstances of occurrence of the insurance event (for example: report from the Traffic Police, HD (history of the disease), result of pre-trial proceedings, etc.)

Appendix 11
SHORT-TERM CORPORATE HEALTH INSURANCE

Required documents for claiming an insurance payment

1. Application for payment of an insurance amount or part thereof by the beneficiary (template of the Insurer) - original;

2. Personally certified with signature and date copy of the identity document of the beneficiary and the legal representative or other representative under power of attorney of the User of the insurance service

3. Official note - information from the employer about occurrence of insurance event (only for group insurances concluded by the employer) -template of the Insurer - original;

4. Insurance policy;

5. In case of hospital treatment - epicrisis, original invoices issued by the hospital;

6. In case of outpatient treatment - outpatient sheets, test results, prescriptions for medicines, original invoices with fiscal receipts for incurred expenses;

7. Certificate of a personal bank account - original;

8. Statement under Article 42, paragraph 2, item 2 of the Measures Against Money Laundering Act - template of the Insurer - original;

* Other documents confirming the date, the cause and the circumstances of occurrence of the insurance event (for example: report from the National Health Insurance Fund, report from the MCC (Medical Consulting Commission), report from the Traffic Police, personal outpatient card (POC), HD (history of the disease), outpatient sheets, epicrises, result of pre-trial proceedings, etc.)