

Liability insurance claim application form

The person submitting this claim application form undertakes to submit to the insurer objective and complete information and to notify the insurer of all known circumstances that are related to the claim. In the event that all of the requested information does not fit on this application form, please use additional sheets of paper.

1. DATA OF THE INSURED PERSON

Name:	Personal identification code/registry code:
Postal address:	
Telephone:	E-mail address:
Policy No.	Term of validity of the policy: / /
Representative's name:	Grounds for the right of representation:
Telephone:	E-mail:

2. CIRCUMSTANCES RELATED TO THE CLAIM

Date of submission of the claim against the insured person:	Amount of claim (in euros):
/ /	
The exact time (date, time) and location (address) of the event that caused the damage:	
/ /	

CLAIMANT'S (INJURED PERSON'S) DATA

Name:	Personal identification code/registry code:
Address:	E-mail:
Telephone:	
In what format has the claim been submitted (written claim, statement of claim, etc.)?	

DATA OF WITNESS(ES)

Name:	Telephone/e-mail:
Name:	Telephone/e-mail:
Name:	Telephone/e-mail:

BENEFICIARY

Given name and surname/company name:	Personal identification code/commercial registry code:
IBAN:	BANK:

1. Describe the event which caused the damage (action, failure to act, or operation):

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2. Was the loss event registered with the police, Rescue Board, emergency medical care, etc.? YES NO

Please submit the administrative agency's data, contact information and the time when the loss event was registered.

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3. Has the person that directly caused the damage submitted (to you) a letter of explanation about the causing of damage? YES NO

If yes, we ask that you please append the person's letter of explanation to this application form.

4. As the insured person, wherein lies your fault/liability, and do you admit to being at fault/liable in causing the damage?

We ask that you please provide justification, including submitting objections to the claim in the case of objections.

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5. On what basis provide by law (reference to the law and the section) are you liable before the injured person?

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6. Do you agree with the claims and evidence submitted by the injured person, including the amount of damage? YES NO

Please justify:

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7. Notes and other information

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Please note! We ask that you please append to this application form the claim submitted by the injured person, all evidence (claim, statement of claim, invoices, checks, calculations, expert's reports, letters of explanation, photos, etc., related to the damage) and documents proving the amount of damage.

3. NOTE TO THE INSURED PERSON

Notification requirement: the insured person undertakes to submit to the insurer true and complete information and to notify the insurer of all known circumstances that are related to the claim.

The competent insurance supervisory body is the Estonian Financial Supervision Authority (Sakala 4, 15030 Tallinn).

In the event that the requested information does not fit on this application form, please use additional sheets of paper.

The insured person confirms:

- that all data presented in this application form is objective and complete;
- that he or she is aware that in the event of the violation of the notification obligation the insurer has the right to reduce or refuse payment of the insurance indemnity;
- that the insurer has the right to process the personal data presented in this application form for the purpose of performing this contract;
- that he or she is aware that as long as the injured person has not submitted a claim for the compensation of damage, along with evidence, against the insured person, Seesam will not begin loss adjustment. In the event that the insured person submits a loss report to Seesam without the injured person's written claims, Seesam will not begin compensation actions before the insured person submits to Seesam the injured person's written claim for compensation against the insured person along with the related evidence.

Insured person's representative

Insured person's signature

Date

Seesam's representative

Seesam's representative signature

Date

INSURER

Compensa Vienna Insurance Group, ADB Estonian branch

Tel: 628 1800

Maakri 19/1, B-building, 10145 Tallinn

E-mail: seesam@seesam.ee

Registry code 12970620