

GENERAL INFORMATION

Insurer: Insurance Company Garantie
 76 Mitropolit Varlamstreet, Chisinau
 MD – 2012 Republic of Moldova

BANK DETAILS

Issuer of the MasterCard: CB Moldova Agroindbank S.A.
 9 Cosmonautilor Street, Chisinau
 MD – 2006 Republic of Moldova

- **Program :** Agroindbank Gold MasterCard

- **Cardholder of the MasterCard (name and address) :**

- **MasterCard Card number (first 6 digits):** - XX – XXXX - XXXX

- **Insured and Trip Details**

- First + Family name : _____
- Address : _____

- Date of Birth : / /
- Telephone home / office : _____
- E-mail : _____
- Country of domicile : _____
- Departure Date : / / from _____ to : _____
- Return Date : / / from _____ to : _____
- Nature of the trip : Private Business
- Number of travelers + relationship to insured / cardholder : _____
- Identity of the victim(s) if not the cardholder : _____

- Relationship to the cardholder : _____

- **Reimbursement (per policy conditions)**

- International Bank Account Number (IBAN) where the loss can be settled : _____
- SWIFT Code : _____
- Name and address of the bank : _____

NOTIFICATION OF LOSS
 (to be duly completed by the cardholder)

- Date of the loss / injury : / /
- Circumstances and location of the loss / injury :
- Description :
- Subrogation possibilities and actions already taken :
- Is there any right of action / recovery against a third party?
- Have you taken any action in this respect yourself?

Personal data: your personal data (hereinafter the "Data") will be processed in accordance with the law of 8 December 1992 on the protection of privacy. The Data will be processed for the purpose of management and optimal use of the services provided by the Insurer, including risk assessment, contract management, claims handling and fraud prevention.
To achieve these objectives, the Insurer may be required to transfer Data to other companies of the Chartis group, to sub-contractors or to partners. These companies, subcontractors or partners may be located in countries outside the European Economic Area that do not necessarily offer the same level of protection as Belgium. The Insurer shall take all precautionary measures to ensure the protection of Data. However, the Insurer cannot avoid all risks related to the processing of Data.
According to the law, the Insured is entitled to access, amend or oppose (for a reasonable cause) to the processing of Data relating to him. To exercise these rights, the Insured can contact the Insurer at any time in writing at Blvd de la Plaine 11, 1050 Brussels.
In as far as necessary and in particular in respect of health related data, the Insured approves the processing and the transfer of the Data within the limits and under the conditions described here above.

Declaration of the insured
 The undersigned certifies the above information to be complete and correct, that these expenses are only in relation to the notified claim and that these expenses have not been claimed with any other company. The undersigned herewith authorises the company to recover the expenses from a liable third party.
 Date + signature of the insured

Please send this claim form together with all required substantiating documents as soon as possible to the CLAIMS OFFICE of which the address is mentioned on the first page.

Travel Accident / Help Student

- **Documents to be enclosed with this present notification :**
 - Medical report
 - Name and address of the hospital
 - Copy of your MasterCard Card statement of account (if not yet available, please send copy of your receipt)
 - Copy of the invoice of the travel
 - In case of loss of life :
 - Certificate of death signed by the competent local authority
 - Evidence of legal beneficiaries signed by the competent local authority
 - All invoices and documents relating to the repatriation
 - Name and address of the insured's executor or legal representative

Declaration of the insured

The undersigned certifies the above information to be complete and correct, that these expenses are only in relation to the notified claim and that these expenses have not been claimed with any other company. The undersigned herewith authorises the company to recover the expenses from a liable third party.

Date + signature of the insured

Please send this claim form together with all required substantiating documents as soon as possible to the Insurer on the address is mentioned on the first page.

Hospitalisation Abroad

- Hospitalisation Abroad
 - Number of days of hospitalisation :
 - Name and address of the hospital : _____

- **Documents to be enclosed with this present notification :**
 - Medical report
 - Original receipts of all medical expenses
 - Copy of the invoice of the travel
 - Copy of your MasterCard Card statement of account (if not yet available, please send copy of your receipt)

Declaration of the insured

The undersigned certifies the above information to be complete and correct, that these expenses are only in relation to the notified claim and that these expenses have not been claimed with any other company.

The undersigned herewith authorises the company to recover the expenses from a liable third party.

Date + signature of the insured

Please send this claim form together with all required substantiating documents as soon as possible to the Insurer on the address is mentioned on the first page.

Delayed Flight / Missed Connection/ Missed Departure

- Detailed description of the exact circumstances and reason for the delay / missed connection :

- Identity of the other co-insured :

Documents to be enclosed with this present notification :

- Copy of your MasterCard Card statement of account (if not yet available, please send copy of your receipt)
- Copy of the invoice of the travel
- Confirmation of competent authorities with a clear indication of the exact span of delay (Property Irregularity Report)
- **Original** expense notes
- Detail of the indemnity received from the transport carrier (if applicable)
- List of expenses following the delay

EXPENSE LIST

Enclosure number + description	Expense Date	Currency	Paid Amount	Paid Euro
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
TOTAL				

Please number and staple substantiating documents together.

Declaration of the insured

The undersigned certifies the above information to be complete and correct, that these expenses are only in relation to the notified claim and that these expenses have not been claimed with any other company. The undersigned herewith authorises the company to recover the expenses from a liable third party.

Date + signature of the insured

Please send this claim form together with all required substantiating documents as soon as possible to the Insurer on the address is mentioned on the first page.
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Luggage Delay

- Duration of the delay and reason :

Arrival of flight on the / / at : hours

Receipt of luggage on the / / at : hours

- Identity of the other co-insured :

- **Documents to be enclosed with this present notification :**

- Copy of your MasterCard Card statement of account (if not yet available, please send copy of your receipt)
- Copy of the invoice of the travel
- Attestation of delayed luggage by the competent local authority or by the travel representative
- Original expense notes

EXPENSE LIST

Enclosure number + description	Expense Date	Currency	Paid Amount	Paid Euro
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
TOTAL				

Please number and staple substantiating documents together.

Declaration of the insured

The undersigned certifies the above information to be complete and correct, that these expenses are only in relation to the notified claim and that these expenses have not been claimed with any other company.

The undersigned herewith authorises the company to recover the expenses from a liable third party.

Date + signature of the insured

Please send this claim form together with all required substantiating documents as soon as possible to the Insurer on the address is mentioned on the first page.
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