Illness-Related Death or Disability Insurance

Notification for lump-sum payments

This form must be completed by the insured person or the insured person's legal representative. You can find all the information about the product and the required form at css.ch/idd. Please complete the form in full and send it to us as quickly as possible to the address shown on the last page. Without your information, we are unable to review your entitlement to benefits. Thank you for your cooperation.

If you are reporting a death, please ignore points 3.1, 3.2 and 3.3.

If you are reporting a disability, please ignore point 2.3.

Question 3.2 does not need to be answered for children younger than 15.

Any questions? Our Contact Center will be happy to help on 0844 277 277.

Client number

☐ Disability ☐ Death

1 General information

1.1 Details of insured person

First Name	Surname	Date of birth	Street address

Postcode / town	E-Mail	Phone	Available at (time)

1.2 Details of person making report

First Name	Surname	Date of birth	Street address

Postcode / town	E-Mail	Phone	Available at (time)

2 Progression of illness

2.1 Start of illness

Date on which illness began	Nature of illness / diagnosis

2.2 Please describe the cause and the progression of the illness in as much detail as possible:

2.3 Date on which death certified?

2.4 Doctor / hospital / dentist providing treatment?

Name	Postcode / town

Other doctor / hospitals / dentists providing treatment?

Name	Postcode / town

Name	Postcode / town

2.5 Date on which treatment began?

2.6 Was this a pre-existing complaint?

☐ Yes ☐ No If so, when did it begin?

3 Federal disability insurance (DI)

3.1 Are you already registered with the federal disability insurance (IV) scheme?

☐ Yes ☐ No

3.2 Are or were you unable to work as a result of the injury?

☐ Yes ☐ No Degree of work incapacity in % from to

3.3 Was a pension granted?

☐ Yes ☐ No

4 Remarks

Please confirm these details with your signature. Many thanks for your support.

The undersigned person hereby confirms that he or she has answered all questions in this form truthfully and in full.
The undersigned person hereby assigns to CSS any liability claims arising from the illness referred to above up to the amount in benefits it has paid and acknowledges that CSS may assert its claims against third parties. By signing the illness notification form, the undersigned authorises CSS to share information and obtain such at any time from doctors, other service providers, social and private insurers and authorities, and its company doctors and medical advisors to the extent necessary to assess the insurance cover while respecting statutory provisions on data protection. In such cases, all parties involved are released from the obligation to maintain professional or patient confidentiality with respect to CSS.

The undersigned person has the right to request information about his or her data that is being processed. Consent to the processing of data may be revoked at any time.

The legal entity for lump-sum Illness-Related Death or Disability Insurance is Helvetia Swiss Life Insurance Company Ltd.

Place	Date	Signature of the insured person or his or her legal representative

Please return to:
CSS Versicherung AG
Special Insurance Competence Center
P. O. Box 2568
6002 Lucerne

Form. 17e-04.22-pdf