

Application Form for International Health Plan (IHP)

This form should be filled out by the applicant or the applicant's legal representative. All applicable questions should be answered in full and the signed form should then be returned promptly to the address at the foot of the page. If you have any questions, contact the IHP agency at +41 58 277 16 87. Thank you in advance.

1 Personal Data

1.1 The Applicant

Customer number	Sex	Civil status
<input type="text"/>	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="text"/>
Name	First name	Date of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>
Nationality	Language	Current profession
<input type="text"/>	<input type="checkbox"/> English <input type="checkbox"/> German <input type="checkbox"/> French <input type="checkbox"/> Italian	<input type="text"/>

Address abroad (if known)

Street, number	Additional address	Postal code/Location
<input type="text"/>	<input type="text"/>	<input type="text"/>

Land of domicile abroad (Please enclose confirmation of the cancellation of your registration issued by the Swiss residents registration office.)

Tel. Numbers abroad (if known)

Private	<input type="text"/>	Mobile	<input type="text"/>	Business	<input type="text"/>
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E-mail

Private	<input type="text"/>	Business	<input type="text"/>
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I herewith agree to transmit delicate personal data (e.g. illnesses/diagnoses etc.) by e-mail.

Yes No

Is the planned stay abroad a secondment*?

Yes No

If so: Those on secondment, as defined under social insurance legislation, are not eligible for an IHP.

(*Seconded employees always remain subject to the contract of employment that they have concluded with their Swiss employer. They also remain covered by social insurance in Switzerland.)

1.2 Address for correspondence (if not identical to "1.1 The Applicant")

Name	First Name
<input type="text"/>	<input type="text"/>
Street, number	Additional address
<input type="text"/>	<input type="text"/>
Postal code/Location	Country
<input type="text"/>	<input type="text"/>
Customer number	Tel. Numbers
<input type="text"/>	Private <input type="text"/> Mobile <input type="text"/> Business <input type="text"/>

2 Payment

We cannot make any payments without account details.

2.1 Premium payer

Insured person

Other premium payer

First name

Surname

Client number

Street, house number/P.O. Box

Address supplement

Postcode/town

Payment by direct debit

Credit to account

IBAN

Name of financial institution

Payment by payment slip (only possible with a Swiss correspondence address)

Due date of premium Semi-annually Annually (discount) Monthly (option applies only for LSV)

You can set up your e-banking portal so that you can pay your premiums by electronic invoice.
Please contact your financial institution in case you experience any problems.

2.2 Recipient of benefits

Credit in accordance with account, para. 2.1

Co-payment in accordance with paragraph 2.1

Insured person

Other recipient of benefits

First name

Surname

Client number

Street, house number/P.O. Box

Address supplement

Postcode/town

Credit to account

Co-payment payable by direct debit

IBAN

Name of financial institution

Co-payment payable by payment slip (only possible with a Swiss correspondence address)

You can set up your e-banking portal so that you can pay your premiums by electronic invoice.
Please contact your financial institution in case you experience any problems.

3 Inception / Franchise / Premium

Insurance period

from (minimum duration of contract 1 year, respectively terminable by the end of a calendar year)

Franchise variation out-patient CHF 300 / in-patient CHF 1000 out-patient CHF 900 / in-patient CHF 3000

Monthly premium (illness and accident)

Premium in CHF

Declaration of health

Medical questionnaire for the insurance applicant

Personal details

First name

Surname

Declaration of health

If you answer any of questions 1, 2, 3, 7 with "Yes" (Details ☐), please provide more precise information under "Details for the health declaration".

*If your child reaches the age indicated on the form in the year the insurance begins, the corresponding questions must be answered.

- 1 Have you
- received inpatient treatment (hospital, withdrawal clinic, spa, rehabilitation, etc.) in the last **10 years**?
 - consulted a doctor (family doctor, psychiatrist, etc.) or therapist (alternative medicine, physiotherapy, nutrition advice, etc.) in the last **5 years** or have you been given a diagnosis?

No

Yes (Details ☐)

For example, because of an illness or disorder of the respiratory tract or respiratory organs; the heart, the cardiovascular or circulatory system; the nervous system or psyche; the digestive organs; the urinary or reproductive organs; the skin or allergies; the muscles, bones, joints or spine; the metabolic system, the blood or infectious diseases; the sensory organs (eyes, ears, nose), tumours or cancers; because of weight problems; another illness, accident or anomaly.

- 2 Are you currently receiving or do you intend to receive treatment from a doctor, dentist and/or therapist (examination, operations, alternative treatment, prevention, check-up, etc.)?

No

Yes (Details ☐)

Have you been fitted with an implant or foreign body (breast implants, prostheses, joint replacement, gastric band, stent, etc.)?

No

Yes (Details ☐)

- 3 Are you currently taking regular medication or have you done so in the last 5 years?
If yes, mention the medication under detailed questions.

No

Yes (Details ☐)

- 4 Have you tested positive for HIV?

No or not tested

Yes

- 5 Do you take or have you taken drugs (cocaine, heroin, narcotics, etc.)?

No

Yes

*From the age of 12

If so, state the drug, and the frequency and period of use.

First name

Surname

Do you or did you regularly drink more than 0.5l wine or 1l beer or 1.5dl spirits per day?

No Yes

*From the age of 12

Have you smoked in the last 5 years?

No Yes

*From the age of 12

If yes, number of cigarettes per day

I have quit smoking since (month/year):

If yes, number of cigars, pipes, etc. per week

I have quit smoking since (month/year):

If yes, number of joints per week

I have quit smoking since (month/year):

6

Height:

cm

Current weight:

kg

*From the age of 6

Women: If you are pregnant, give your weight immediately before pregnancy:

kg

(For benefits in case of maternity a waiting period of 9 months, calculated from the beginning of the insurance, is effective.)

7

Are you currently receiving a daily indemnity, a pension or benefits from another insurer (e.g. IV, UV, MV, daily sickness indemnity, etc.) or have you done so in the last 5 years? If yes, please enclose a copy of the decision (e.g. IV certificate).

No Yes (Details \hookrightarrow)

In the last 5 years have you been completely or partially incapacitated and unable to work for a period lasting longer than 3 weeks or are you currently incapacitated and unable to work?

No Yes (Details \hookrightarrow)

8

Have insurance applications for life, accident or health insurance ever been rejected or was their acceptance ever made only with special conditions (e.g. exclusions from cover)?

No Yes

If yes, for what reason and with which insurance company:

9

Name and address from the doctor who knows best about the history of your health state:

Details for the declaration of health

Concerns question	Diagnosis	Body part left/right	Reason, cause, information, remarks, symptoms	Frequency (once, every 3 weeks, permanent, etc.)	Treatment, disorders (month/year) from to		Type of treatment (operation, physiotherapy, endoscopy, x-ray, CT, medication, etc.)	Treatment administered by (name and address)	Cured completely without any consequences?
									<input type="checkbox"/> No <input type="checkbox"/> Yes
									<input type="checkbox"/> No <input type="checkbox"/> Yes
									<input type="checkbox"/> No <input type="checkbox"/> Yes
									<input type="checkbox"/> No <input type="checkbox"/> Yes
									<input type="checkbox"/> No <input type="checkbox"/> Yes
									<input type="checkbox"/> No <input type="checkbox"/> Yes
									<input type="checkbox"/> No <input type="checkbox"/> Yes

First name Surname The applicant or his/her legal representative

Place Date

Important conditions VVG

I confirm that existing insurance contracts will continue in their current form. I wish to conclude a contract / several contracts with CSS Versicherung AG (hereinafter "Insurer") as shown in the application. By signing this application I agree that a separate contract will be drawn up with the Insurer for each supplementary insurance plan if the application is accepted.

I declare that I agree to be bound by the application for 14 days (4 weeks if medical examinations are necessary) and undertake to pay the premiums due until the insurance ends if a contract is concluded.

I confirm that the information about me in this application form is accurate, correct and truthful, even if the answers to questions were written by the client advisor, an intermediary or a third party. If questions are answered incompletely or untruthfully, the Insurer has the right to withdraw from the contract under the provisions of the current General Insurance Conditions (AVB) and the Federal Insurance Contract Act (VVG).

I confirm that I have received a copy of the relevant AVB, Supplementary Conditions (ZB) and Special Conditions (SB) and agree to recognize such in their entirety.

I further confirm that I have been made aware of the information by means of a summary sheet as required under the provisions of Art. 3 VVG and Art. 45 of the Insurance Supervision Act (VAG).

If the insurance is changed, any current "Special Conditions" (such as exclusions from the Insurance) continue to apply with the same scope in the amended insurance product. I undertake to inform the Insurer without delay if I withdraw from the group of insured under a framework contract for supplementary health insurance. I authorize the Insurer to verify that I still belong to the group of individuals insured under a framework contract for supplementary health insurance. I confirm that I have been informed of the terms for the continuation of discounts in the insurance policy as well as those leading to loss or change of such.

I agree that my data may be used to the extent necessary in each case within CSS Versicherung AG for the purposes of risk assessment, to investigate breach of the disclosure requirement, to process claims, for Managed Care and for marketing.

I further authorise the Insurer to share information and/or obtain such at any time from doctors, other service providers, social and private insurers, and authorities to the extent necessary in each case to assess the insurance cover, investigate breach of the disclosure requirement and settle claims. With respect to the foregoing, I release all those who might be asked to give information from the obligation to maintain professional secrecy with respect to the Insurer.

I also authorize the Insurer to share information and/or obtain such at any time from doctors, other service providers, social and private insurers, and the authorities to the extent necessary in each case in order to assess the insurance cover and settle claims. With respect to the above, I release all persons asked from the obligation to maintain professional secrecy vis-à-vis the Insurer. I am aware that the insurer and its agent will process my personal data when I sign the contract and hereby give them my express consent. Furthermore, I am aware and agree that my data can be passed on to insurance carriers of CSS Group that are not contracting parties for the purpose of managing the contract. Validity of this application is subject to any changes in insurance plans and premiums and to approval by the Swiss Financial Market Supervisory Authority (FINMA). To become final, this contract must be approved by the management of the Insurer. The legal entity is CSS Versicherung AG, Tribschenstrasse 21, 6005 Lucerne.

I acknowledge that concluding an International Health Plan (IHP) does not automatically release me from statutory insurance obligations in my host country. The policyholder is responsible for finding out about the insurance obligations which apply in the country in question.

Special conditions

Owing to regulatory requirements, this application is valid only if the person to be insured under the application is still resident in Switzerland at the time the insurance is taken out. Further to Art. 6 of the General Insurance Conditions (version of 01.2009), this also applies to newborn infants.

Signatures (Insurance plan in compliance with VVG)

Place	Date	The applicant or his/her legal representative
<input type="text"/>	<input type="text"/>	<input type="text"/>
Place	Date	The broker or adviser
<input type="text"/>	<input type="text"/>	<input type="text"/>
Person number of insurance salesman	Agency number	
<input type="text"/>	<input type="text"/>	

CSS Versicherung AG
International Health Plan
Tribschenstrasse 21
P.O. Box 2568
CH-6002 Lucerne

ihp.info@css.ch

