Your address:

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Your current basic insurer under the KVG:

.....

Your current supplementary insurer under the VVG:

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.....

.....

Cancellation of my insurance

Details of insured person (one form to be filled in for each person)

Last name .....

First name ..... Date of birth .....

Street ..... Postcode / town .....

☐ **Cancellation of basic insurance under the KVG**

I confirm that I wish to cancel my basic insurance cover effective ..... or on the next possible date.

Current policy number .....

☐ Please forward this cancellation form on my behalf.
☐ I confirm that I will cancel / have cancelled the insurance myself.

☐ **Cancellation of supplementary insurance under the VVG**

Please note that the form cancelling your existing supplementary insurance will only be forwarded if you have been admitted to our supplementary insurance without reservation.

I confirm that I wish to cancel my supplementary insurance cover effective ..... or on the next possible date.

Current policy number .....

Remark .....

☐ Please forward this cancellation form on my behalf.
☐ I confirm that I will cancel / have cancelled the insurance myself.

Place, date

.....

Signature of the insured person or their legal representative

.....

Please send us this form at least 10 days before the end of the notice period. Please note that if you do not submit the form by the given deadline, we cannot guarantee that your cover with your previous insurer will be cancelled in due time.

To be completed by the insurer

This serves as confirmation from the new insurer
In accordance with Art. 7 para. 5 of the Federal Health Insurance Act (KVG), we confirm that we have admitted the above-named person to the mandatory health insurance of CSS Kranken-Versicherung AG / Arcosana AG (delete as appropriate) as of ..... (date). We would therefore ask you to cancel this person's cover under your own health insurance and to confirm to us that you have done so.

Place, date

.....

Insurer
(Double signature mandatory)

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