



Questionnaire for treatment abroad

For emergency treatments

This form should be filled out by the insured person or his or her legal representative. All applicable questions should be answered in full and the signed form should then be sent promptly to the address on the last page of the form. If you have any questions, contact the CSS Serviceline on 0844 277 277. Thank you in advance.

Client number

1 General information

1.1 Insured person

| | | |
|----------------------|----------------------|----------------------|
| First name | Last name | Date of birth |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

| | |
|----------------------|----------------------|
| Street, No. | Postal code/Town |
| <input type="text"/> | <input type="text"/> |

1.2 Contact

| | | |
|----------------------|----------------------|----------------------|
| Phone private | Cell phone | Phone business |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

| | |
|--|----------------------|
| What time is the best time to contact you? | E-mail |
| <input type="text"/> | <input type="text"/> |

Where? Private Cell phone Business

2 Questions

2.1 Is this an

Illness Accident, please complete enclosed accident report form in full Maternity

2.2 Type of illness or injury

Precise description, type of illness or injury, or precise description of the event.

2.3 When and where did you suffer the illness or accident?

| | |
|----------------------|----------------------|
| Date | Time |
| <input type="text"/> | <input type="text"/> |

| | |
|----------------------|----------------------|
| Place | Country |
| <input type="text"/> | <input type="text"/> |

2.4 What treatment did you receive abroad from the doctor or hospital?

2.5 Duration of the treatment

Outpatient treatment

Inpatient treatment

Date

Date

from to

from to

2.6 Costs of the treatment

CHF Foreign currency, which one

Outpatient treatment

Inpatient treatment

| | CHF | Foreign currency |
|--------------|----------------------|----------------------|
| Doctor costs | <input type="text"/> | <input type="text"/> |
| Medication | <input type="text"/> | <input type="text"/> |
| Total | <input type="text"/> | <input type="text"/> |

| | CHF | Foreign currency |
|----------------|----------------------|----------------------|
| Hospital costs | <input type="text"/> | <input type="text"/> |
| Medication | <input type="text"/> | <input type="text"/> |
| Total | <input type="text"/> | <input type="text"/> |

2.7 Doctor/hospital that first treated you (abroad or in Switzerland)

| | | | |
|------------------|----------------------|-------------|----------------------|
| First name | <input type="text"/> | Last name | <input type="text"/> |
| Hospital | <input type="text"/> | Street, No. | <input type="text"/> |
| Postal code/Town | <input type="text"/> | Country | <input type="text"/> |

2.8 Further treatment by doctor/hospital abroad or in Switzerland

| | | | |
|------------------|----------------------|-------------|----------------------|
| First name | <input type="text"/> | Last name | <input type="text"/> |
| Hospital | <input type="text"/> | Street, No. | <input type="text"/> |
| Postal code/Town | <input type="text"/> | Country | <input type="text"/> |

2.9 Had you already received medical treatment in Switzerland for the ailment? Yes No

If yes, when and from whom?

Date
from to

| | | | |
|-------------|----------------------|------------------|----------------------|
| First name | <input type="text"/> | Last name | <input type="text"/> |
| Street, No. | <input type="text"/> | Postal code/Town | <input type="text"/> |

2.10 Do you also have other insurance (sickness/accident/transport costs/ETI cover note etc.)? Yes No

If yes, which insurance company?

| | | | |
|---------------------------|----------------------|--|----------------------|
| Name of insurance company | <input type="text"/> | Policy No. (please enclose copy of policy) | <input type="text"/> |
| Street, No. | <input type="text"/> | Postal code/Town | <input type="text"/> |

Have you already reported the incident to this insurance company? Yes No

2.17 Remarks

The signatory declares that he/she has answered all the questions on each page completely and truthfully.

By signing the questionnaire for treatment abroad the signatory authorizes CSS to share and obtain information at all times from doctors, other service providers, state and private insurers, authorities, and company physicians and medical advisors of the foregoing as needed to assess the insurance cover while respecting the provisions of data privacy legislation. With respect to the foregoing the signatory releases all agencies from the obligation to maintain professional secrecy or patient confidentiality with respect to CSS Insurance.

The signatory is entitled to request information about his or her data that is being processed. Permission to process data may be revoked at any time.

Legal entity for the basic insurance (KVG): CSS Health Insurance Ltd, INTRAS Health Insurance Ltd or Arcosana Ltd*;
legal entity for supplementary insurance plans (VVG): CSS Insurance Ltd or INTRAS Insurance Ltd*

*The legal entity responsible for your basic insurance (KVG) and your supplementary insurance plans (VVG) is shown on your insurance policy.

Translation: Only the original German text is binding.

Town

Date

Signature of the insured person or his or her legal guardian

Address of the insurance company:
CSS Insurance
Service Center, P.O. Box 2550, 6002 Lucerne