Reset Print

Swiss Life Ltd, General-Guisan-Quai 40, P.O. Box, 8022 Zurich

# Application for daily hospital indemnity

**Contract no.** _____

**Please note**
The earliest submission date for the application is a stay in hospital of 30 days or at the end of a stay in hospital or at a health resort. Applications relating to treatment at a health resort must be accompanied by the referring doctor's therapy prescription.

You can find our data protection declarations at https://www.swisslife.ch/en/privacy.

## Details pertaining to the insured person

Name _____ First Name _____

Street, no. _____ Postcode, Place _____

Date of birth _____ Telephone / mobile phone _____

E-mail address _____

## Information from the insured person

Nature of the illness or injury _____

Was it an accident? ☐ yes ☐ no

Date of first doctor's appointment _____

Referring physician (name, address) _____

Were you treated previously for the same complaint? ☐ yes ☐ no

If yes, from _____ to _____

By which doctor or at which hospital?

Name, address _____ year _____

## Remarks

_____

_____

_____

_____

## Authorisation

I am aware of the fact, that Swiss Life requires certain data concerning my personal details for the examination of the claim to benefits. Failure to provide this data can lead to rejection of the requested claim

Swiss Life may forward this data, including highly sensitive personal data, to other insurers and reinsurers in Switzerland and abroad for the purpose of assessing benefits and combating insurance fraud. I also consent to Swiss Life obtaining information on the claims experience to date from the public authorities, insurers and reinsurers in Switzerland and abroad involved in the claim.

I hereby release hospitals, doctors, psychologists, therapists and corresponding staff of health insurers, short-term disability benefit insurers, health and accident insurers, AHV and IV offices, life insurers, pension funds, social insurers, reinsurers and other third parties who may provide information in connection with the occurrence of the claim from their duty of professional secrecy and their medical, contractual and statutory duty of confidentiality and authorise them to make records available for inspection and to disclose such information to Swiss Life, as is required to assess the case, and in particular to investigate the claim for insurance benefits.

I further authorise Swiss Life to transmit information and documents (incl. medical records and files available to us from other insurance companies involved) to other insurers, such as to health insurers, short-term disability benefit insurers, health and accident insurers, AHV and IV offices, life insurers, pension funds and reinsurers, as well as to experts and physicians, for the purpose of processing benefits.

All declarations and consents granted shall, within the scope of their purpose, also apply without a time limit beyond death. I can revoke my consent towards Swiss Life at any time. Such revocation is only effective for the future and may render the provision of services impossible. Swiss Life may also process personal data following a revocation if this is permitted by law or is required for overriding interests.

Policy/Reference no. _____

Name _____ First name _____

Place, date

Signature of the insured person

_____ _____

## Registration certificate

**Note**

Please have the hospital or convalescent centre complete the registration certificate. You can also submit a copy of the invoice to us with the entry and departure date.

☐ Hospitalisation from _____ to _____ from _____ to _____

☐ Cure treatment from _____ to _____ from _____ to _____

Reason ☐ aftermath of accident ☐ illness ☐ childbirth

Place, date

Stamp and signature of hospital or convalescent centre administration

## Payout

The benefit is paid out to (please make a selection):

- ○ Policyholder / Contracting party
- ○ Spouse / Registered partner
- ○ Life partner residing in the same household
- ○ Children / Grandchildren
- ○ Parents / grandparents
- ○ Siblings
- ○ Pillar 2 employee benefits institution
- ○ Recognised non-profit organisations
- ○ Persons / Bodies with contractual or other legal entitlement

If payment is not made to the policyholder / contracting party, a copy of a valid official identity document must be submitted (front and back of identity card) for the natural payment recipient.

Valid identity documents:
Passport, identity card (Switzerland, Liechtenstein and Schengen countries), Swiss driving licence (credit card format only), Swiss residence permit for foreign nationals.

As an alternative to a copy of a valid official identity document, a copy of a letter from a public authority (e.g. tax document, electricity bill) can also be submitted.

Depending on the outcome of the individual examination, additional documents may be requested.

**Internal use** (to be completed by advisor)

Swiss Life contract / premium account no. _____

Investment solution / 3a Start IBAN _____

In the name of _____

Amount* CHF _____

* Do not specify an amount if investing the whole sum.

**Financial institution**

IBAN _____

Account no. (outside Europe) _____

SWIFT code (outside Europe) _____

Name of financial institution _____

Address of financial institution _____

Country of financial institution _____

Account holder (nat./leg. Person[1]) _____

Account holder's residential/domicile address (if different from policyholder / contracting party) _____

[1] For operating legal entities / partnerships, the "Identification of the controlling persons of operational legal entities and partnerships (excl. domiciliary companies)" form must be submitted if the individual payout reaches or exceeds CHF 15 000.00.

With domiciliary companies (non-operative controlling partnerships/partnerships), the form "Ascertainment of beneficial owner" shall be completed by the policyholder / contracting party.

*If the account holder is not the same as the policyholder / contracting party, the following additional information must be provided:*

**Account holder (nat./leg.)**

Last name, first name/company name _____

Residential/domicile address _____

Date of birth/foundation _____

Nationality/country of domicile _____

I confirm that I am authorised to disclose personal data about third parties by the respective third parties within the scope of the initiation, execution or processing of the contract and that I have expressly drawn their attention to the data protection information for the processing of personal data. I confirm that the personal data communicated about third parties is correct to the best of my knowledge.

_____ _____

Place, date Signature of the policyholder / contracting party