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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.

Details pertaining to the insured person

Name _____ First Name _____

Street, no. _____ Postcode, Place _____

Date of birth _____ Telephone / mobile no. _____

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

I agree, that my personal details (name, first name, gender, date of birth, occupation, address) as well as my health details for the purpose of the examination of the claim to benefits can be handled by Swiss Life. Swiss Life can transmit these details for examination of the claim to benefits and for measures to combat insurance misuse, to affiliated companies as well as other participating insurers and reinsurers inland and abroad.

I am also in agreement, that Swiss Life can obtain information concerning the examination to the claim to benefits from affiliated companies as well as governmental offices and from third parties, especially from primary insurers regarding previous claims history.

I hereby release hospitals, doctors, psychologists, therapists and relevant staff of health insurers, short-term disability benefit insurers, health and accident insurers, AHV and IV offices, life insurers, pension funds, reinsurers and other third parties who are able to provide information in connection with the occurrence of the claim, from their duty of professional secrecy or 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. In order to combat insurance fraud, Swiss Life may forward this data to other Group companies and to third parties.

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

Payment to the following financial institution:

○ **Financial institution in Switzerland**

IBAN _____

Name of financial institution _____

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

Residential address/domicile of account holder (if different to policyholder) _____

○ **Financial institution in Europe**

IBAN _____

Name of financial institution _____

Address of financial institution _____

Country of financial institution _____

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

Residential address/domicile of account holder (if different to policyholder) _____

☐ **Financial institution outside Europe**

Bank account no. _____

SWIFT code _____

Name of financial institution _____

Address of financial institution _____

Country of financial institution _____

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

Residential address/domicile of account holder (if different to policyholder) _____

[1] With operative controlling persons/business partnerships, the form "Identification of the controlling persons of legal entities/partnerships" shall be submitted.

With domiciliary companies (non-operative controlling persons/partnerships) the form "Ascertainment of beneficial owner" shall be completed through the applicant/policyholder.

If the payment recipient is not the person entitled under the contract, the following information is also required:

Entitled person (nat./leg. Person)

Last name, first name/company _____

Residential/domicile address _____

Date of birth/foundation _____

Nationality/country of domicile _____

_____ _____

Place, date Signature