Power of attorney



| Contract number: | |
|--|--|
| Employer: | |
| Address: | |
| | |
| Employee | |
| Last name, first name: | |
| Date of birth: | |
| Insured person's no.: | |
| Address: | |
| | |
| To the extent required for the administ event), the undersigned hereby releas other and previous employee benefits foreign insurers and consulting physici with Swiss Life and the responsible en and persons to provide Swiss Life and (including medical data) and to grant the istration of employee benefits will be of medical data being forwarded within S and for the data to be forwarded to other the undersigned also agrees that his/litions for clarification and for any subsections and processing to third parties. The data will be handled in strict confidence. | al secrecy and the right to inspect and share files tion of employee benefits (risk assessment/settlement of the actual insured the Swiss Federal Disability Insurance, Military Insurance, accident insurers, stitutions, sickness benefit and statutory short-term sick pay providers, any as from the duty to maintain professional and official secrecy in their dealings to oyee benefits foundations and authorises the above-mentioned institutions to employee benefits institution – if required – with the necessary information must right to inspect files. Only information actually required for the admin- ained. In addition, the undersigned consents to his/her personal details and the second of the purpose of assessing benefits and combating insurance fraud tinsurers, reinsurers and experts involved. The data may – to the extent required – be submitted to the mandated institu- tient initiation of needs-oriented, individual assistance (care management/ andersigned further acknowledges that Swiss Life is entitled to assign data tiality by Swiss Life, the responsible employee benefits institution and any third tely for the contractually agreed settlement of the pension or insurance contract. |
| Place and date | Employee signature |