Notification of hospitalisation

Daily Hospital Indemnity Insurance

This form must be completed by the insured person or the insured person's legal representative. You can find all the information about the product and the required form at css.ch/hospitalisation. Please complete the form in full and send it to us as quickly as possible to the address shown on the last page. Without your information, we are unable to review your entitlement to benefits. Thank you for your cooperation.
Any questions? Our Contact Centre will be happy to help on 0844 277 888.

Client number

1 General information

1.1 Hospitalised person

First name

Surname

Date of birth

Street, house number

Postcode / town

2 Hospitalisation

2.1 Hospital

Name of hospital

Street, house number

Postcode / town

2.2 Referring doctor

First name

Surname

Street, house number

Postcode / town

3 To be completed and confirmed by the referring doctor or the hospital

3.1 Hospitalisation

First name | Surname | Client number

Admission

Date

Discharge

Date | Definitive number of days in hospital

Stay in normal ward

Date

from ____ to ____

Stay in intensive care

Date

from ____ to ____

3.2 Reason for hospitalisation

Exact diagnosis and ICD 10 code

3.3 When was the illness ☐ / the accident ☐ / the pregnancy ☐ first diagnosed / detected? (Please tick)

Date

3.4 Has the patient received medical treatment in the past 4 years for the above-named condition/complaint?

☐ No ☐ Yes, when ____

Comments

The undersigned person hereby confirms that he or she has answered all questions on all pages truthfully and in full.

Place | Date

Doctor's signature | Doctor's stamp

Please return to:
CSS Versicherung AG
Special Insurance Competence Center
P. O. Box 2568
6002 Lucerne

Authorisation

Daily Hospital Indemnity Insurance

Client number

Insured person

First name | Surname | Date of birth

Street, house number | Postcode / town

Comments

The undersigned person hereby confirms that he or she has answered all questions on all pages truthfully and in full.

By signing this form, the undersigned person authorises CSS to share information and documents and obtain such at any time from doctors, other service providers, social and private insurers and authorities, and its company doctors and medical advisors to the extent necessary to assess the insurance cover while respecting statutory provisions on data protection. In such cases, all parties involved are released from the obligation to maintain professional secrecy or patient confidentiality with respect to CSS.

The undersigned person is entitled to request information about the data pertaining to him or her that is being processed. Consent to the processing of data may be revoked at any time.

Legal entity for basic insurance (KVG): CSS Kranken-Versicherung AG, legal entity for supplementary insurance (VVG): CSS Versicherung AG

Place | Date

Signature of the insured person or his or her legal representative

Please return to:
CSS Versicherung AG
Special Insurance Competence Center
P. O. Box 2568
6002 Lucerne

Form. 11e-04.22-pdf