Application Form for International Health Plan (IHP)

This form should be filled out by the applicant or the applicant's legal representative. All applicable questions should be answered in full and the form should then be returned promptly to the address at the foot of the page. If you have any questions, contact the IHP agency at +41 58 277 16 87. Thank you in advance.

1 Personal Data

1.1 The Applicant

Customer number

Sex ☐ Female ☐ Male

Civil status

Name

First name

Date of Birth

Nationality

Language ☐ English ☐ German ☐ French ☐ Italian

Current profession

Address abroad (if known)

Street, number

Additional address

Postal code / Location

Land of domicile abroad (Please enclose confirmation of the cancellation of your registration issued by the Swiss residents registration office.)

Tel. Numbers abroad (if known)

Private Mobile Business

E-mail

Private Business

I herewith agree to transmit delicate personal data (e.g. illnesses/diagnoses etc.) by e-mail. ☐ Yes ☐ No

Is the planned stay abroad a secondment*? ☐ Yes ☐ No
If so: Those on secondment, as defined under social insurance legislation, are not eligible for an IHP.
(*Seconded employees always remain subject to the contract of employment that they have concluded with their Swiss employer. They also remain covered by social insurance in Switzerland.)

1.2 Address for correspondence (if not identical to "1.1 The Applicant")

Name

First Name

Street, number

Additional address

Postal code / Location

Country

Customer number

Tel. Numbers

Private Mobile Business

2 Payment

We cannot make any payments without account details.

2.1 Premium payer*

☐ Insured person ☐ Other premium payer

First name | Surname | Client number

Street, house number / P.O. Box | Address supplement | Postcode / town

☐ Payment by direct debit ☐ Credit to account

IBAN | Name of financial institution

☐ Payment by payment slip (only possible with a Swiss correspondence address)

Due date of premium ☐ Semi-annually ☐ Annually (discount) ☐ Monthly (option applies only for LSV)

You can set up your e-banking portal so that you can pay your premiums by electronic invoice.
Please contact your financial institution in case you experience any problems.

*see css.ch/contractroles

2.2 Recipient of benefits*

☐ Credit in accordance with account, para. 2.1 ☐ Co-payment in accordance with paragraph 2.1

☐ Insured person ☐ Other recipient of benefits

First name | Surname | Client number

Street, house number / P.O. Box | Address supplement | Postcode / town

☐ Credit to account ☐ Co-payment payable by direct debit

IBAN | Name of financial institution

☐ Co-payment payable by payment slip (only possible with a Swiss correspondence address)

You can set up your e-banking portal so that you can pay your premiums by electronic invoice.
Please contact your financial institution in case you experience any problems.

*see css.ch/contractroles

3 Inception / Franchise / Premium

Insurance period

from ____ (minimum duration of contract 1 year, respectively terminable by the end of a calendar year)

Franchise variation ☐ out-patient CHF 300 / in-patient CHF 1000 ☐ out-patient CHF 900 / in-patient CHF 3000

Premium in CHF

Monthly premium (illness and accident)

Declaration of health

Medical questionnaire for the insurance applicant

Personal details

First name

Surname

Declaration of health

If you answer any of questions 1, 2, 3, 7 with "Yes" (Details ↳), please provide more precise information under "Details for the health declaration".
*If your child reaches the age indicated on the form in the year the insurance begins, the corresponding questions must be answered.

1 Have you
- received inpatient treatment (hospital, withdrawal clinic, spa, rehabilitation, etc.) in the last **10 years?**
- consulted a doctor (family doctor, psychiatrist, etc.) or therapist (alternative medicine, physiotherapy, nutrition advice, etc.) in the last **5 years** or have you been given a diagnosis?

For example, because of an illness or disorder of the respiratory tract or respiratory organs; the heart, the cardiovascular or circulatory system; the nervous system or psyche; the digestive organs; the urinary or reproductive organs; the skin or allergies; the muscles, bones, joints or spine; the metabolic system, the blood or infectious diseases; the sensory organs (eyes, ears, nose), tumours or cancers; because of weight problems; another illness, accident or anomaly.

☐ No ☐ Yes (Details ↳)

2 Are you currently receiving or do you intend to receive treatment from a doctor, dentist and/or therapist (examination, operations, alternative treatment, prevention, check-up, etc.)?

☐ No ☐ Yes (Details ↳)

Have you been fitted with an implant or foreign body (breast implants, prostheses, joint replacement, gastric band, stent, etc.)?

☐ No ☐ Yes (Details ↳)

3 Are you currently taking regular medication or have you done so in the last 5 years? If yes, mention the medication under detailed questions.

☐ No ☐ Yes (Details ↳)

4 Have you tested positive for HIV?

☐ No or not tested
☐ Yes

5 Do you take or have you taken drugs (cocaine, heroin, narcotics, etc.)?

☐ No ☐ Yes
*From the age of 12

If so, state the drug, and the frequency and period of use.

First name | Surname

Do you or did you regularly drink more than 0.5l wine or 1l beer or 1.5dl spirits per day? ☐ No ☐ Yes
*From the age of 12

Have you smoked in the last 5 years? ☐ No ☐ Yes
*From the age of 12

If yes, number of cigarettes per day | I have quit smoking since (month/year):

If yes, number of cigars, pipes, etc. per week | I have quit smoking since (month/year):

If yes, number of joints per week | I have quit smoking since (month/year):

6 Height: cm | Current weight: kg
*From the age of 6

Women: If you are pregnant, give your weight immediately before pregnancy: kg

(For benefits in case of maternity a waiting period of 9 months, calculated from the beginning of the insurance, is effective.)

7 Are you currently receiving a daily indemnity, a pension or benefits from another insurer (e.g. IV, UV, MV, daily sickness indemnity, etc.) or have you done so in the last 5 years? If yes, please enclose a copy of the decision (e.g. IV certificate). ☐ No ☐ Yes (Details ↳)

In the last 5 years have you been completely or partially incapacitated and unable to work for a period lasting longer than 3 weeks or are you currently incapacitated and unable to work? ☐ No ☐ Yes (Details ↳)

8 Have insurance applications for life, accident or health insurance ever been rejected or was their acceptance ever made only with special conditions (e.g. exclusions from cover)? ☐ No ☐ Yes

If yes, for what reason and with which insurance company:

9 Name and address from the doctor who knows best about the history of your health state:

Details for the declaration of health

Concerns question	**Diagnosis**	**Body part left / right**	**Reason, cause, information, remarks, symptoms**	**Frequency** (once, every 3 weeks, permanent, etc.)	**Treatment, disorders** (month / year) from	to	**Type of treatment** (operation, physiotherapy, endoscopy, x-ray, CT, medication, etc.)	**Treatment administered by** (name and address)	**Cured completely without any consequences?**
									☐ No ☐ Yes
									☐ No ☐ Yes
									☐ No ☐ Yes
									☐ No ☐ Yes
									☐ No ☐ Yes
									☐ No ☐ Yes

First name

Surname

Place

Date

The applicant or his / her legal representative

Important conditions VVG

I confirm that existing insurance contracts will continue in their present form. I wish to conclude a contract/several contracts with CSS Versicherung AG (hereinafter referred to as “the Insurer”) in the form requested. By consenting to this application I agree that, if the application is accepted, a separate contract will be entered into with the Insurer for each supplementary insurance plan.
I declare that I agree to be bound by the application for 14 days (4 weeks if medical examinations are necessary) and undertake to pay the premiums due until the insurance ends if a contract is concluded.
I confirm that the information about me in this application form is accurate, correct and truthful, even if the answers to questions were written by the client advisor, an intermediary or a third party. If questions are answered incompletely or untruthfully, the Insurer has the right to withdraw from the contract under the provisions of the current General Insurance Conditions (AVB) and the Federal Insurance Contract Act (VVG).
I confirm that I have received a copy of the relevant AVB, Supplementary Conditions (ZB) and Special Conditions (SB) and agree to recognize such in their entirety.
I further confirm that I have been made aware of the information by means of a summary sheet as required under the provisions of Art. 3 VVG and Art. 45 of the Insurance Supervision Act (VAG).
If the insurance is changed, any current “Special Conditions” (such as exclusions from the Insurance) continue to apply with the same scope in the amended insurance product. I undertake to inform the Insurer without delay if I withdraw from the group of insured under a framework contract for supplementary health insurance. I authorize the Insurer to verify that I still belong to the group of individuals insured under a framework contract for supplementary health insurance. I confirm that I have been informed of the terms for the continuation of discounts in the insurance policy as well as those leading to loss or change of such.
I agree that my data may be used to the extent necessary within CSS Versicherung AG to check the application, to investigate a breach of the notification requirement, to process claims, and for Managed Care and marketing. To this end, CSS Versicherung AG may carry out profiling.
I further authorise CSS Versicherung AG to share information and/or to obtain the required information at any time from doctors, other service providers, social and private insurers, and authorities to the extent necessary to assess the insurance cover, to investigate a breach of the notification requirement and to settle claims. With respect to the foregoing, I release all those who might be asked to give information from their statutory duty of confidentiality with respect to CSS Versicherung AG.
I agree that CSS Versicherung AG, other insurance carriers of the CSS Group that are not contracting parties and any brokers may process my data for the aforementioned purposes.
Validity of this application is subject to any changes in insurance plans and premiums and to approval by the Swiss Financial Market Supervisory Authority (FINMA).
To become final, this contract must be approved by the management of the Insurer. The legal entity is CSS Versicherung AG, Tribschenstrasse 21, 6005 Lucerne.
I acknowledge that concluding an International Health Plan (IHP) does not automatically release me from statutory insurance obligations in my host country. The policyholder is responsible for finding out about the insurance obligations which apply in the country in question.

Special conditions

Owing to regulatory requirements, this application is valid only if the person to be insured under the application is still resident in Switzerland at the time the insurance is taken out. Further to Art. 6 of the General Insurance Conditions (version of 01.2009), this also applies to newborn infants.

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Signatures (Insurance plan in compliance with VVG)

Place	Date	The applicant or his/her legal representative

Place	Date	The broker or adviser

Person number of insurance salesman	Agency number

CSS Versicherung AG
International Health Plan
Tribschenstrasse 21
P.O. Box 2568
CH-6002 Lucerne

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