



Resignation from the Collective Daily Cash Benefit for Sickness Insurance and/or Supplementary Accident Insurance (FLAI/VG)

Insured person

Surname, forename _____	Date of birth _____
Street, No. _____	Sex: m <input type="checkbox"/> f <input type="checkbox"/>
Postal code, Town _____	Nationality _____
Phone _____	Residence permit _____
Phone (business) _____	Profession _____
Cell phone _____	

When you resign from the Collective Daily Cash Benefit Insurance, you have the right to transfer to the **Individual Daily Cash Benefit Insurance** without having your health checked if you do so within 3 months.
The right to transfer to the individual insurance must be exercised within 30 days in the case of insurance plans pursuant to the FLAI/UVG.

Declaration by the insured person

<input type="checkbox"/> I intend to leave/have left the firm.	On (date) _____
<input type="checkbox"/> My employer's collective insurance contract will be/has been dissolved.	On (date) _____
<input type="checkbox"/> I am interested in continuing the insurance and would like to receive a personal quotation for insurance.	For which insurance plans? <input type="checkbox"/> Individual Daily Cash Benefit Insurance <input type="checkbox"/> Individual Accident Insurance
<input type="checkbox"/> I waive my right to continue the insurance concerned. (In this case there is no need to answer any further questions; please sign the form.)	
<input type="checkbox"/> I would like to consult an insurance adviser.	Best time to contact me _____
<input type="checkbox"/> I intend to remain in the Collective Daily Cash Benefit Insurance (only valid GCI 2006 and older)	

Please note: Until you are fully fit for work or until the maximum benefit period has been attained, you will continue to receive daily cash benefits for an existing condition. New illnesses are not covered. No premium is payable if you remain a member of the collective contract.

Supplementary questions (only to be answered if you want a quotation to transfer)

1. Are you unfit for work/gainful employment?	<input type="checkbox"/> No	<input type="checkbox"/> If so, why? <input type="checkbox"/> Illness <input type="checkbox"/> Accident
2. Are you unemployed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (If possible include a copy of the first settlement/confirmation by the ALV)
If so, do you have dependent children?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3. Do you have a new employment contract?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, beginning on (date) _____
If so, does your new employer already have a collective daily cash benefit insurance?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
4. Do you intend to work in a self-employed capacity?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, beginning on (date) _____

By signing the form I confirm that I have been informed about my legal right to transfer to Visana's individual insurance. It has been brought to my notice that the insurance cover under my former employer's collective daily cash benefit insurance and/or supplementary FLAI insurance will be terminated when my employment contract ends. I also verify that the statements made above are true.

Place, date _____

Signature _____

Please use a ballpoint pen and write in capitals
Page 2: Details of employer



Insured person

Forename, surname _____

Town _____

Details of employer

Name of company _____

Contact _____

Street, No. / P.O. Box _____

Phone _____

Fax _____

Postal code, Town _____

E-mail _____

We require the following information if you wish to transfer to another insurance:

1. Date of joining the company	per (date)	_____	
2. Annual salary insured	CHF	_____	
3. Contract no(s).	Collective Daily Cash Benefit Insurance	FLAI Supplementary Insurance	_____
4. Insured group (designation, if more than one)	Collective Daily Cash Benefit Insurance	FLAI Supplementary Insurance	_____
5. For Collective Daily Cash Benefit Insurance	Benefits _____% of salary	Waiting period _____ days	_____

Place, date _____

Stamp and signature _____

Please use a ballpoint pen and write in capitals

Please complete the form, sign it and send it to the agency responsible.

You can get the address from your (former) employer.