Insurance Application
for Dental Treatment Insurance (IPA/VVG)

All pronouns used refer to males and females and also apply in the plural sense.

Option			Monthly premium									
Share	Limit per year		EA (00–18)	EA (19–25)	EA (26–30)	EA (31–35)	EA (36–40)	EA (41–45)	EA (46–50)	EA (51–55)	EA (56–60)	EA (61–65)	EA (66–xx)
◯ 50 %	max. CHF 600.– per year		7.30	13.10	15.30	22.20	26.80	31.40	33.70	37.50	37.50	37.50	37.50
◯ 75 %	max. CHF 600.– per year		9.10	16.30	19.10	27.70	33.50	39.20	42.10	46.80	46.80	46.80	46.80
◯ 50 %	max. CHF 1200.– per year		14.50	26.10	30.60	44.40	53.60	62.80	67.40	75.00	75.00	75.00	75.00
◯ 75 %	max. CHF 1200.– per year		18.10	32.50	38.20	55.40	66.90	78.40	84.10	93.60	93.60	93.60	93.60
◯ 75 %	max. CHF 1500.– per year		21.70	39.00	45.80	66.50	80.20	93.90	100.80	112.30	112.30	112.30	112.30
◯ 75 %	max. CHF 1800.– per year		25.30	45.40	53.40	77.50	93.50	109.50	117.50	130.90	130.90	130.90	130.90
◯ 75 %	max. CHF 3000.– per year		39.70	71.40	83.90	121.70	146.90	172.00	184.60	205.60	205.60	205.60	205.60
◯ 75 %	max. CHF 5000.– per year		57.70	103.80	122.10	177.10	213.70	250.40	268.70	299.20	299.20	299.20	299.20

CHF

Total monthly premium IPA/VVG

Accident cover excluded
EA: effective age
Share: insurance cover in %
Limit: maximum sum in CHF per calendar year

Valid from 01 · ·

Personal data

Insured person

Family name / Given name

Current profession

Street / No.

Postcode / Town

Political commune

Foreign national identity card

Phone No. (private) Phone No. (business)

E-mail

Date of birth · ·

Sex ◯ m ◯ f Language ◯ g ◯ f ◯ i

Visana insurance No. · · ·

◯ New admission Previous insurer

◯ Modification ◯ Trial application ◯ Transfer to single / collective

Method of payment

◯ Method of payment analogue to the insurance application for other insurances.
Premium payer (only enter details that differ from those of the insured person)

Name			
Given name			
Street / No.			
Postcode / Town			
Phone No. (private)		Phone No. (business)	

Payment method for premiums and co-payment invoices

◯ LSV+ (direct debit by the bank)* ◯ Debit Direct (Swiss Post)* ◯ Invoice / Payment slip ◯ E-Billing

* Please complete the LSV+ / Debit Direct form
* Please send us the completed LSV+ / Debit Direct form as soon as possible.
We would like to draw your attention to the fact that the start of LSV+ debiting may be delayed by the filing of the LSV+ direct debit authorisation at the bank and might come into effect later than desired. Until the LSV+ direct debit authorisation is enabled, you will receive pay-in slips with which to pay premiums and co-payments.

Invoicing

◯ monthly ◯ bimonthly ◯ quarterly ◯ semiannually (1% discount) ◯ annually (2% discount)

Bank or postal payment

Postal account No.	
Name of the bank	
IBAN No.	
Postcode / Town (branch)	

Health data

Declaration of health

1. Did you in the past / do you regularly take medicinal products? ◯ Yes ◯ No

If so, since when / for how long?

Which medicinal products?

2. Do you suffer from a disability or a congenital defect? If so, please include a copy of the IV ruling. ◯ Yes ◯ No

If so, give the type of disability / congenital defect.

3. Are you currently having dental treatment or is such planned? ◯ Yes ◯ No

If so, give the name and address of the dentist:

4. How often do you have dental check-ups? ◯ Never ◯ 1× per year ◯ 2× per year

5. How often do you attend the dental hygienist? ◯ Never ◯ 1× per year ◯ 2× per year

Note to the applicant
Please have the enclosed dental certificate completed by a dentist with a Swiss diploma. The cost of this certificate and that of the necessary check-up and X-rays has to be borne by the applicant. Entitlement to benefits from the dental treatment insurance begins after a qualifying period of at least 6 months after beginning of insurance according to the GCI.

Dental health questionnaire

Insured person (details mandatory from the age of 4 on)

Name / Given name	Date of birth

Address

Please enclose originals of recent X-rays (less than two years old) along with the completed questionnaire. X-rays only need to be enclosed for children if available. X-ray images must be enclosed for children above the age of 16. X-rays will be returned after they have been evaluated.

Please answer each question!

1. When did the last dental check-up take place? (This should be no more than 1 year ago.)

   Date

2. Does the applicant suffer from an illness that affects / could affect the condition of teeth? ◯ Yes ◯ No

   If so, which?

3. Has the applicant had dental check-ups and scaling and polishing? ◯ Yes ◯ No

   If so, at what intervals?

4. Is specific treatment planned? ◯ Yes ◯ No

   If so, which treatment and when will this take place?

5. Does the applicant have tooth abrasion or erosion? ◯ Yes ◯ No

   If so, why?

6. Does the applicant suffer from a malformation of the teeth or jaw? ◯ Yes ◯ No

   If so, what is the nature of the malformation?

7. Does the applicant have fillings? ◯ Yes ◯ No

   If so, what is the condition of the fillings? ◯ bad ◯ average ◯ good

8. Does the applicant have a permanent or removable prosthesis? ◯ Yes ◯ No

   If so, what is the condition of the prosthesis? ◯ bad ◯ average ◯ good

9. Oral hygiene? ◯ bad ◯ average ◯ good

10. What is the condition of the parodontium? If available please enclose pocket index. ◯ bad ◯ average ◯ good

11. Does the applicant have gaps in teeth or hypodontia? ◯ Yes ◯ No

    If so, please mark which teeth.

    55 54 53 52 51 | 18 17 16 15 14 13 12 11 | 21 22 23 24 25 26 27 28 | 61 62 63 64 65
    85 84 83 82 81 | 48 47 46 45 44 43 42 41 | 31 32 33 34 35 36 37 38 | 71 72 73 74 75

12. Does the applicant have carious teeth? ◯ Yes ◯ No

    If so, please mark which teeth.

    55 54 53 52 51 | 18 17 16 15 14 13 12 11 | 21 22 23 24 25 26 27 28 | 61 62 63 64 65
    85 84 83 82 81 | 48 47 46 45 44 43 42 41 | 31 32 33 34 35 36 37 38 | 71 72 73 74 75

13. Has the applicant had root treatment on teeth? ◯ Yes ◯ No

    If so, please mark which teeth.

    55 54 53 52 51 | 18 17 16 15 14 13 12 11 | 21 22 23 24 25 26 27 28 | 61 62 63 64 65
    85 84 83 82 81 | 48 47 46 45 44 43 42 41 | 31 32 33 34 35 36 37 38 | 71 72 73 74 75

14. Does the applicant have teeth which have been damaged in an accident? ◯ Yes ◯ No

    If so, please mark which teeth.

    55 54 53 52 51 | 18 17 16 15 14 13 12 11 | 21 22 23 24 25 26 27 28 | 61 62 63 64 65
    85 84 83 82 81 | 48 47 46 45 44 43 42 41 | 31 32 33 34 35 36 37 38 | 71 72 73 74 75

The dentist signing below confirms that the questionnaire has been filled out truthfully. Answering questions incompletely or providing false information may lead to refusal to pay benefits, the addition of a proviso or cancellation of the contract. The cost of this certificate, the necessary check-up and X-rays has to be borne by the applicant.

Town / Date	Dentist's stamp and signature

Conditions of insurance

The signatory declares (mark with a cross where applicable)

☐ that he / she has applied to join an insurance regulated by the IPA/VVG (Insurance Policies Act) on the basis of this application to Visana Insurance Ltd and

- that he / she has answered the above questions completely and truthfully to his / her best knowledge and belief at the time;
- that all dentists, doctors, hospitals, health insurance and insurance companies, which at the time of the application and in the future may be able to give information about the applicant's state of health and any benefits received, are released from their obligation to maintain professional secrecy to the extent needed to process this current application;
- that he / she has received a copy of the General Conditions of Insurance (GCI) for the insurance he / she is applying for and recognises such as binding;
- that he / she is aware that Visana Insurance Ltd can check statements made in this application against data on benefits paid available to Visana Insurance Ltd, Visana Ltd, sana24 Ltd or vivacare Ltd to which the company may have access. This capability of the company to check facts does not dispense the applicant from the obligation to provide complete and truthful answers to the preceding questions;
- that he / she agrees that the information about the top-up insurance regulated by the IPA/VVG (Insurance Policies Act) for which he / she has contracted can be retrieved electronically by means of the insurance card.

I further confirm

☐ that I have received the information from the advisor as stipulated in art. 45 IOA/VAG;
☐ that I have received a copy of the "VAG/IOA Customer Information" sheet.

☐ **I hereby authorise**
Visana Insurance Ltd to pass on information from any past exclusion or cases where insurance has been refused to my advisor.

Town / Date	Signature

Town / Date	Signature of the applicant or his / her legal guardian	Advisor's family name, given name Stamp and signature of advisor No.: