

Application for hospital daily allowance insurance

1 Policyholder

Surname
 First name
 Street, no.
 Additional address info/PO box
 Postcode, town/city
 Political commune
 Phone no. (private) Phone no. (business)
 Email
 Gender m f Language GER FRE ITA

2 Insured person

Surname
 First name
 Nationality Foreign national identity card
 Date of birth
 Current professional activity self-employed employed
 Phone no. (private) Phone no. (business)
 Gender m f Email
 Visana insurance no. OASI/AHV no.
 New admission Re-entry Former insurer
 Modification Transfer individual / collective
 Admission to collective insurance yes no Group no.
 Company / association¹ / society¹
(¹ Attach evidence of membership)

3 Premium payer

Address (only complete the details which differ from those of the policyholder)

Surname
 First name
 Street, no.
 Additional address info / PO box
 Postcode, town/city
 Phone no. (private) Phone no. (business)
 Gender m f Email

Method of payment

Invoicing

monthly bi-monthly quarterly semi-annually (discount 1 %) annually (discount 2 %)

Payment

PostFinance account no.
 Name of the bank
 IBAN
 Postcode, town/city (branch)

Preferred payment method for premiums and out-of-pocket expenses invoices

E-billing QR invoice Direct Debit (Swiss Post) * LSV+ (direct debit by the bank) *

* Please fill in the Swiss Direct Debit / LSV+ form.

Please note that LSV+ will no longer be offered from September 2028 onwards. We therefore recommend using the e-billing or QR-invoice payment options. If you still wish to use LSV+ until September 2028, please send us the completed LSV+ / Debit Direct form as soon as possible. Please note 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 QR invoices for payment of premiums and out-of-pocket expenses.

Insured person

Surname First name
 Date of birth . .

4 Application for hospital daily allowance insurance as per IPA/VVG (the insurer is Visana Insurance Ltd)

Commencement of insurance

Multi-year contract (discount) 3 years (2%) 5 years (3%)
(tacit extension of the contract for 1 year on expiry of the contractual period)

Hospital daily allowance	With accident	Without accident		
Waiting period	1 day	3 days		
Indemnity period	30 days	60 days	90 days	
Daily allowance amount	CHF			
Note:	Minimum = CHF 50.–	Maximum = CHF 500.–	Scalable in increments of CHF 50.–	CHF

Premiums subject to approval by the FINMA (Swiss Financial Market Supervisory Authority)

Basis for premiums: premiums from the year 20

Please note: the current offer is based on the premiums for

You will be informed of the definite premiums for 20 on the policy that is issued in autumn 20

Total monthly premium IPA/VVG CHF

Insured person

Surname First name

Date of birth

5 Health declaration

If accident cover is to be included in an existing insurance policy that is offered in compliance with IPA/VVG, questions 2 – 5, 8, 9, 10 and 13 need only be answered in respect of accidents suffered.

Please state the name of your treating physician / the hospital (name and address) best able to provide information on your medical history.

Have other applications previously been refused or deferred by Visana or other insurers, or only accepted under more stringent conditions (e.g. exclusion of cover, deferral, risk surcharge or disclaimer)?

If so, why, and on the basis of what diagnosis?
yes no

1	Physical characteristics	Height (cm)	Weight (kg)					
2	a	Are you currently receiving medical treatment (conventional, complementary or dental /orthodontic) or are you under medical supervision or having therapy, check-ups or tests?		yes	no			
	b	Are you awaiting any medical, dental, orthodontic, therapeutic or complementary / naturopathic treatments, assessments, check-ups, interventions / operations (including cosmetic or aesthetic ones) or spa therapies? Or have you planned any of the above, or have they been approved but not implemented?		yes	no			
	If so:	Planned, date	/diagnosis	Recommended, diagnosis	Recommended, not implemented, diagnosis			
3	In the last 5 years have you ever had treatment / check-ups / examinations for a physical or mental ailment, or for cosmetic reasons, as an outpatient / inpatient from a physician / complementary practitioner / therapist?				yes	no		
	a	Respiratory system / organs?	yes	no	b	Heart and arterial disease, varicose veins, high / low blood pressure?	yes	no
	c	Epilepsy, neurological illnesses, migraine?	yes	no	d	Psychiatric disorders, psychotherapy, anorexia, bulimia?	yes	no
	e	Digestive organs?	yes	no	f	Urinary or reproductive organs?	yes	no
	g	Skin or allergies?	yes	no	h	Muscles, bones, joints or spinal column?	yes	no
	i	Ailments caused by tumours?	yes	no	j	Sensory organs (eyes, ears, nose)	yes	no
	k	Blood or infectious diseases?	yes	no	l	Any other ailment or disorder not indicated above?	yes	no
	m	Metabolic system and glands, e.g. pancreas, diabetes, thyroid, high cholesterol levels?				yes	no	
	n	High-risk pregnancy / pregnancy complications				yes	no	
4	Are you currently unfit for work?				yes	no		
5	In the last 10 years, have you been unable to work or earn an income?		From (month/year)	to (month/year)	yes	no		
	If so, why?							
6	Have you ever had tumours (cancer)? If yes, date? Type of complaint or treatment given at the time:				yes	no		
7	Have you ever had treatment for adiposity (gastric band or other treatment)?				yes	no		
8	Do you suffer from the consequences of an illness or accident?				yes	no		
9	Do you have a congenital condition, or are you / have you been in receipt of benefits from the Swiss Federal Invalidity Insurance, Accident Insurance or Military Insurance? (Please attach evidence)				yes	no		
10	Is your ability to work restricted and / or are you already receiving benefits from other loss of earnings or pension insurance plans? (Please attach evidence)				yes	no		

If you have answered "yes" to one or more of the questions in parts 2 to 10, please give more details here:

Illness/Accidents/Disability/Complaint/ Treatment	When/How long/End of treatment	Treating physician/Hospital/Therapist (Name and address) Degree of incapacity to work	Cured without consequences	
			yes no	
			yes no	
			yes no	
			yes no	
11 a	Do you have a misaligned jaw/misaligned teeth, has suspicion of this been expressed or has treatment been recommended? (If a cost estimate is available, please attach this.)		yes no	
b	Has an assessment, treatment or correction of the misalignment been planned or has treatment already begun? Name and address of the orthodontist/dentist:		yes no	
12	Have you ever been tested for HIV / hepatitis (hepatitis B, C)? If so,	Result of the HIV test Result of the hepatitis test	positive negative positive negative	yes no
13	Do you take/or have you regularly taken any medication in the last five years? (Excluding contraceptive pills) If so, which? Quantity per day for which illness/complaint		From (month/year) to (month/year)	yes no

Insured person

Surname First name
 Date of birth

Continued health declaration

14	Have you ever used / do you use drugs? If so, which? From (month/year) to (month/year) Frequency	yes	no
15	Do you drink alcohol regularly / have you done so in the past? (More than 0.5 l of wine or 1 l of beer or 1 dl of spirits per day) Please give details. From (month/year) to (month/year) dl Quantity per day	yes	no
16	Do you smoke, or did you ever smoke or consume snus (oral snuff) in the last 10 years? If so, what? From (month/year) to (month/year) Quantity per day/ml per day (vapes)	yes	no
17	Are you pregnant? If so, please give the estimated date of birth Weight before pregnancy kg	yes	no

The signatory declares that he/she has answered the questions in the health declaration form completely and truthfully.

Place / Date

Signature of the applicant or his/her legal guardian

6 Terms and conditions of contract

By signing this document, (mark the statement which applies with an X)

- I am applying to take out the aforementioned top-up insurance as per IPA/VVG (Insurance Policies Act).
- I acknowledge that this is not a request for a quotation, but a binding application to enter into an insurance contract as per IPA/VVG.
- I confirm that the information in this insurance contract and regarding health issues is complete, correct and truthful, and corresponds exactly to the information I have provided – even if answers were written by the advisor or a third party.
- I authorise Visana Insurance Ltd, as well as the companies Visana Services Ltd and Health Insurance Solutions Ltd, which operate on its behalf, to obtain information, e.g. regarding medical diagnoses, findings, treatments, therapies, medication, incapacity to work and existing or previous insurance relationships. Such information may be obtained from service providers (e.g. physicians, hospitals or therapists), private or social insurance providers (e.g. health and accident insurance providers) and other parties (e.g. authorities), which I hereby release from their statutory or contractual duty of confidentiality. I authorise the Visana Group companies operating in the insurance sector (Visana Insurance Ltd, Visana General Insurance Ltd., Visana Ltd, sana24 Ltd and Galenos Ltd) and Health Insurance Solutions Ltd to exchange such information. I consent to the processing of such information as described for the purpose of carrying out application assessment and risk assessment, as well as for clarification of any possible failure to disclose.
- I confirm that I have received the General Conditions of Insurance (GCI), Supplementary Conditions (SC) and/or Supplementary Conditions of Contract (SCC) pertaining to the insurance applied for, and that I accept these conditions.
- I acknowledge that the end of the employment relationship or termination of the membership of the association/society entails automatic reassignment from the collective insurance policy to the individual insurance policy in the following month.
- I agree that the information regarding the supplementary insurance arranged pursuant to the Swiss Federal Insurance Policies Act (IPA / VVG) is digitally accessible by means of the insured person's card.
I declare that I have hereby applied for acceptance into the voluntary daily allowance insurance scheme pursuant to HIA/KVG (Federal Act on Health Insurance) and have understood that incorrect statements shall entail a retrospective insurance restriction.

I agree

that insurance applications from family members that have been accepted without exclusion are processed before all family members have been accepted without exclusion.

The applicant further confirms,

that he/she has received the information about the advisor as stipulated in art. 45 VAG/IOA;
 that he/she has received a copy of the consultation protocol from the advisor;
 that he/she has received the "IPA/VVG Customer Information" sheet and – provided Visana Legal Protection Insurance is being applied for – the "Legal Protection Customer Information" sheet.

Family contract

I agree that my contract will be managed together with the family contract Joint administration in a family contract means that all correspondence and documents (e.g. correspondence relating to the admission decision, insurance contract or benefit reimbursements, documents such as insurance policies, insurance cards and benefits statements, or invoices for premiums and out-of-pocket expenses) are processed under one family policy. The person defined as the head of the family thus receives all correspondence and documents, including sensitive personal data relating to health and legally binding information or notifications, and is responsible for the payment of premiums and out-of-pocket expenses.

Visana accepts no liability for the outcome of any disclosure of data by the head of the family, nor is it liable for the consequences of any delay in the forwarding of information by the head of the family to the insured person.

I hereby consent to Visana Ltd / sana24 Ltd / Galenos Ltd / Visana Insurance Ltd sending and forwarding all correspondence to the head of the family. The head of the family will thus have access to all data, including sensitive data about my health. This consent is valid until revoked and can be revoked in writing at any time.

The applicant hereby authorizes

Visana Insurance Ltd to pass on information to his/her advisor about any past exclusions from insurance or instances where insurance has been refused.

Place, date

Signature

Are there other current agreements pursuant to IPA/VVG for the duration of the products as per the application?

A copy of the previous insurance policy must be submitted with the application. I agree to any double insurance. I am aware that as such until the end of the insurance agreement, I shall pay the premiums to my current insurer and to Visana. I hereby expressly consent to a postponement of the start of the top-up insurance as far as is necessary. I am aware that Visana reserves the right to require a further health declaration and that in this case, the top-up insurance applied for may subsequently only be granted in limited form or even refused.

Place and date

Advisor's surname, first name

Signature of the applicant or his/her legal representative

Advisor's signature

No.: