Power of attorney

Personal

Insurance no.		Date of birth	
Surname		Street, no.	
First name		Postcode, town / city	

Authorises the person named below

Surname		Postcode, town / city	
First name		Phone (personal / work)	
Date of birth		Email	
Street, no.			

to act on insurance matters relating to the Visana Group (Visana Versicherungen AG, Visana AG, Visana Allgemeine Versicherungen AG, sana24 AG, vivacare AG and Galenos AG) and to carry out the following actions:

(Please tick where applicable)

- ◯ Change insurance
- ◯ Submit cancellations
- ◯ Change payment details
- ◯ Provide information
  (excluding medical or health-related data)

OR (do not select both)

- ◯ Provide information
  (including medical and health-related data)

- ◯ Receive **all** correspondence

OR (do not select both)

- ◯ Receive the **following** correspondence
  - ◯ Insurance policy / quotes / adhesive labels / insurance card
  - ◯ Customer magazine
  - ◯ Premium invoices
  - ◯ Benefits statements / invoices for out-of-pocket expenses
  - ◯ Personal correspondence
    (may include medical information)

Benefits and premium reimbursements to be:

(Please tick where applicable)

- ◯ Refunded to the current payment account
- ◯ Refunded to the payment account **of the authorised agent**

IBAN: **CH**

This mandate takes effect on the date of signature and remains valid until revoked in writing. The person granting the power of attorney hereby releases the Visana Group and its employees – within the scope of the power of attorney granted – unconditionally from their duty of professional secrecy or statutory duty of confidentiality in relation to the person to whom the power of attorney is granted, for the purpose of performing the requested services.

Town / date	Signature of the authorised agent
Signature of the insured person	

By signing this form, you consent to the storage your personal data in our system and its use for the administration of our insurance services.