



DECLARATION OF POWER OF ATTORNEY.

SWICA Healthcare Organisation consists of SWICA Healthcare Insurance Ltd, SWICA Insurances Ltd and SWICA Management Ltd

A copy of an official identity document for both the insured person and the person being authorised must be enclosed for identification purposes. Please complete the form in block capitals.

INFORMATION ABOUT THE INSURED PERSON (PERSON GRANTING AUTHORISATION)

Surname

First name

SWICA insured person no.

Date of birth

(day/month/year)

Gender

Male

Female

Street/no.

Postcode/town

Email

PERSON BEING AUTHORISED

Surname

First name

Date of birth

(day/month/year)

Gender

Male

Female

Street/no.

Postcode/town

Phone (daytime)

Email

Please use this address for correspondence (please tick if applicable)

Relationship to the person to be insured

Spouse/registered partner

Cohabiting partner

Legal representative/parent

Child

Advisor/guardian

Other

DECLARATION OF AUTHORISATION

I hereby authorise the above-named person to act on my behalf vis-à-vis SWICA Healthcare Organisation and to represent me legally in the **following** insurance-related matters with immediate effect. To this end I hereby release SWICA Healthcare Organisation and all employees involved in these matters unreservedly from their non-disclosure obligations and their statutory confidentiality obligation vis-à-vis the above-named person. I recognise all actions undertaken by the above-named person on the basis of this authorisation as legally binding on me at all times.

Please tick where applicable:

- Change personal details (e.g. name, marital status, address, payment details, bank details)
- Making of all changes to mandatory basic insurance
- Making of all changes to supplementary insurance plan(s)
- Termination of basic insurance
- Termination of supplementary insurance plan(s)
- Obtaining of personal and health-related information
- Submission of personal and health-related information

- Receipt of all correspondence
- Receipt of the **following** correspondence:
 - Insurance policy
 - Premium invoices
 - Benefit statements/co-payment statements
 - General correspondence
 - Decisions
 - Insured person's card
 - Tax statement
 - Customer magazine

FURTHER RESTRICTIONS SPECIFIED BY THE PERSON GRANTING AUTHORISATION

This authorisation comes into force on the date on which the authorisation is signed. It remains in force until it is revoked in writing, even after death, declaration as a missing person or loss of capacity to act of the insured person.

<div></div> <div>Place/Date</div>	<div></div> <div>Signature of the policyholder (parent or guardian)</div>
<div></div> <div>Place/Date</div>	<div></div> <div>Signature of authorised representative</div>

Please complete and sign the form and return it, together with copies of the required identity documents, to SWICA Client Services. You will find the address on your insurance policy. Thank you.

