Termination

Your name and address:

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Please send this document to SWICA and not directly to your health insurer. We guarantee that it will only be forwarded if you are insured with SWICA unconditionally and in accordance with your wishes.

Registered letter
(Exact address of your current health insurance company)

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Date of postmark

Dear sir or madam

I hereby terminate my insurance plan(s) with your company with effect from ________________ or the next possible date.

Insurances to be terminated (Check as appropriate)

Surname	________________	☐ KVG basic insurance	as of	________
Name	________________	☐ VVG supplementary insurance	as of	________
Date of birth	________ (Day/Month/Year)	Ins. no. ________________		
Surname	________________	☐ KVG basic insurance	as of	________
Name	________________	☐ VVG supplementary insurance	as of	________
Date of birth	________ (Day/Month/Year)	Ins. no. ________________		
Surname	________________	☐ KVG basic insurance	as of	________
Name	________________	☐ VVG supplementary insurance	as of	________
Date of birth	________ (Day/Month/Year)	Ins. no. ________________		
Surname	________________	☐ KVG basic insurance	as of	________
Name	________________	☐ VVG supplementary insurance	as of	________
Date of birth	________ (Day/Month/Year)	Ins. no. ________________		
Surname	________________	☐ KVG basic insurance	as of	________
Name	________________	☐ VVG supplementary insurance	as of	________
Date of birth	________ (Day/Month/Year)	Ins. no. ________________		

Please do not try to persuade me to rejoin.

Yours faithfully

Place, date:	**Signature of insured person**	**Signature of spouse/partner**	**Signature of young person above age 18**

Insurance confirmation for the attention of the above-mentioned health insurance company
Pursuant to Art. 7, para. 5 of the KVG Health Insurance Act, we hereby confirm acceptance of the above person(s) in the statutory basic health insurance scheme as of ________________ . This confirmation applies only if the insured person(s) has (have) fully paid all premiums, co-payments, interest on arrears and debt collection costs. Please make a necessary arrangement for those person(s) to leave your health insurance scheme.

SWICA Healthcare Insurance Ltd

Place/date:	Contact person at SWICA:	Signature:

129e / online / 7.2018 / SW