Switzerland KVG/VVG

Policy separation

Details about the new policy/invoice recipient

Surname (policyholder)

First name

SWICA insured person no.

Date of birth (day/month/year)

Address (street/place/postcode)

Phone (daytime)

Email

Information about memberships

Name of employer*

Association with membership**

*If group insurance with SWICA is in effect
**Please submit a copy of the association membership.

Other co-insured family members to be included in the new contract

(Please also include the first name, surname, date of birth and insured person number.)

Validity

☐ Separation effective from the next invoice date ☐ Separation effective from

Address valid from

(Invoice amounts that have already been paid cannot be refunded or reallocated.)

Desired payment method for premiums and co-payments

(possible only through a Swiss/Liechtenstein bank or postal account)

Premiums paid by
- ☐ E-billing/eBill*
- ☐ Direct debit/Debit Direct**
- ☐ Payment slip (ESR)
- ☐ Premium collection company

Invoicing for premiums
- ☐ Monthly
- ☐ Every two months
- ☐ Quarterly
- ☐ Every six months
- ☐ Annually

Co-payments paid by
- ☐ E-billing/eBill*
- ☐ Direct debit/Debit Direct**
- ☐ Payment slip (ESR)

*After receiving your insurance policy, please register for e-billing with your bank/post office.
**Please enclose completed direct debit/Debit Direct form.
We will send you payment slips (ESR) for payment of your premiums and co-payments until your bank authorises the direct debit facility.

Account for credits

(possible only through a Swiss/Liechtenstein bank or postal account)

Account holder

IBAN (bank or post office) CH

Place/Date	Signature of policyholder	Signature of other parent*	Signature young people above age 18

*Necessary only if invoices so far were for the entire family.

230e / online / 6.2025

Payment authorization with right of contestation CH-DD COR1 Direct Debit (Swiss COR1 Direct Debit) on the PostFinance Ltd postal account or direct debit scheme LSV+ on the bank account

SWICA

SWICA Gesundheitsorganisation, Generaldirektion, Römerstrasse 37, 8400 Winterthur

Debit Direct subscriber (RS-PID) **41101000000647953** LSV-IDENT. **SWA1W**

Details of the payer (customer)

Insured party no. ______ Company ______

Last name ______ First name ______

Street, no. ______ Postcode, town ______

Tel. no. (home) ______ Tel. no. (work) ______

E-mail ______ Date of birth ______

I would like to pay my premiums via the following direct debit procedure:

☐ through PostFinance (Swiss COR1 Direct Debit) ☐ through my bank (LSV+)

I would like to pay my premiums at the following intervals:

☐ monthly ☐ every two months ☐ every three months ☐ semi-annually ☐ annually

I would like to have my cost contribution debited directly from my account:

☐ through PostFinance (Swiss COR1 Direct Debit) ☐ through my bank (LSV+)

Debit of postal account with CH-DD COR1 Direct Debit (Swiss COR1 Direct Debit)

The customer hereby authorizes PostFinance to debit from his or her account the amounts due as indicated by the above invoice issuer, until such a time as this authorization is revoked.

Last name/first name account holder ______

IBAN (postal account) ______

If the account does not contain sufficient funds, PostFinance can check on their availability several times but is not obliged to execute the debit. The customer will be notified by PostFinance of every debit from the account in the agreed-upon form (e.g. on the account statement). The debited amount will be re-credited to the customer if he or she submits an objection to PostFinance in a legally binding form within 30 days of the notification date.

Please return the completed payment authorization to the invoice issuer's **address as provided above.**

Place, date ______ Signature(s)* ______

*Signature of the person giving the authorization or of the authorized agent on the postal account. For collective signatures, two signatures are required.

Debit authorization for my bank account (LSV+)

I hereby authorize my bank to execute the debits (in CHF) from the above creditor to my account until such time as this authorization is revoked.

Last name/first name account holder ______

Name of bank ______ Postcode, town ______

IBAN (bank account) ______

If there are insufficient funds in my account, my bank is not obliged to execute the debit. I will be notified of all debits to my account. The amount debited will be reimbursed if I submit a binding contestation to my bank within 30 days of the notification date. I hereby authorize my bank to inform the creditor in Switzerland or abroad of the content of this debit authorization and of its subsequent cancellation (if applicable) by whatever means it deems suitable.

Please return the completed payment authorization to the invoice issuer's **address as provided above.**

Place, date ______ Signature ______

Amendment (leave blank, to be completed by the bank)

IBAN ______

Date ______ Bank's stamp and initials ______