POLICY MERGER.

1 / 3

DETAILS ABOUT THE INSURED PERSON

Surname

First name

SWICA insured person no.

Date of birth (day/month/year)

Relationship to contact person for the contract   Spouse   Cohabiting partner   Father/mother of adult

Other

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.)

DETAILS ABOUT THE RECIPIENT OF THE NEW POLICY/INVOICE (CONTACT PERSON FOR THE CONTRACT)

Surname

First name

SWICA insured person no.

Phone (daytime)

VALIDITY

Merger effective from next invoice date   Merger effective from

Address valid from

DESIRED PAYMENT METHOD FOR PREMIUMS AND CO-PAYMENTS

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

Complete this section only if the account details of the contact person for the contract change.

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

Name

First name

SWICA insured person no.

Date of birth   (day/month/year)

Joint administration for families and couples
Joint insurance management also means that all documents (e.g. admission decisions, premium and co-payment invoices, benefit statements, insurance policies, insurance cards, tax certificates, correspondence on benefit refunds, insurance coverage) in connection with the insurance relationship are managed as a family policy (payment facility for the family), that the person defined below as the "contact person for the contract" is regarded as the payer of all premiums for the family policy (i.e. the contact person for the contract must ensure that the premiums of all policyholders of the family policy are paid in full), and that co-payments and correspondence recipients are updated and receive the benefit payments. Accordingly, SWICA will send or forward all correspondence and information contained therein to the contact person for the contract, including particularly sensitive personal data such as health data. In principle, delivery includes all items sent by post, including rulings, legally binding notifications and decisions that are subject to a deadline. SWICA accepts no liability for the consequences if the contact person for the contract discloses data, and SWICA cannot be held liable for any consequences arising if the contact person for the contract fails to pass on information to the insured person in due time. This power of attorney is valid until revoked and can be revoked at any time.

Place/Date	Signature of the contact person for the contract	Signature of the insured person	Signature young people above age 18

THERE FOR YOU, 24 HOURS A DAY, 365 DAYS A YEAR.
Phone 0800 80 90 80 **/** swica.ch

SWICA

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, 8401 Winterthur

Debit Direct subscriber (RS-PID) **4110100000647953**   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