Insurance application
Dental care insurance as per IPA/VVG

Note: To be filled in once the age of 4 has been reached (the decisive date is that on which the application is signed).

All references to persons refer to persons of both genders and to multiple persons.

Option			Monthly premium									
Share	Limit per year		EA (00–18)	EA (19–25)	EA (26–30)	EA (31–35)	EA (36–40)	EA (41–45)	EA (46–50)	EA (51–55)	EA (56–60)	EA (61–65)	EA (66–xx)
◯ 50%	max. CHF 600.– per year		7.60	13.60	15.90	23.10	27.90	32.60	35.00	39.00	39.00	39.00	39.00
◯ 75%	max. CHF 600.– per year		9.40	16.90	19.80	28.80	34.70	40.60	43.60	48.60	48.60	48.60	48.60
◯ 50%	max. CHF 1200.– per year		15.00	27.00	31.70	46.00	55.50	65.00	69.80	77.70	77.70	77.70	77.70
◯ 75%	max. CHF 1200.– per year		18.70	33.70	39.60	57.50	69.30	81.20	87.20	97.10	97.10	97.10	97.10
◯ 75%	max. CHF 1500.– per year		22.40	40.30	47.40	68.80	83.00	97.20	104.30	116.20	116.20	116.20	116.20
◯ 75%	max. CHF 1800.– per year		26.20	47.10	55.30	80.20	96.80	113.40	121.70	135.50	135.50	135.50	135.50
◯ 75%	max. CHF 3000.– per year		41.10	73.90	86.90	126.10	152.10	178.20	191.20	213.00	213.00	213.00	213.00
◯ 75%	max. CHF 5000.– per year		59.80	107.60	126.50	183.50	221.40	259.40	278.30	310.00	310.00	310.00	310.00

CHF

Accident excluded
EA: effective age
Share: insurance cover in %
Limit: maximum sum in CHF per calendar year

Total monthly premium as per IPA/VVG

Start of insurance 01 · ·

Personal details

Insured person

Visana insurance no.

Surname, first name

Street, no.

Postcode, town/city

Foreign national ID

Phone (private) Phone (business)

Email

Date of birth · ·

Gender ◯ M ◯ F Language ◯ G ◯ F ◯ I

◯ New admission

◯ Alteration

◯ Re-admission

Premium payer

Address (only fill in details that differ from those of the insured person)

Surname			
First name			
Street, no.			
Additional address info / PO box			
Postcode, town/city			
Phone (private)		Phone (business)	
Email			

Gender ◯ M ◯ F Language ◯ G ◯ F ◯ I

Method of payment/Invoicing

◯ monthly ◯ bimonthly ◯ quarterly ◯ semi-annually (1% discount) ◯ annually (2% discount)

Payment transactions

PostFinance account no.		Name of bank	
IBAN			
Postcode, town/city (branch)			

Preferred payment method for premiums and invoiced out-of-pocket expenses

◯ LSV+ (direct debit by the bank)* ◯ Debit Direct (Swiss Post) * ◯ Invoice / pay-in slip ◯ E-Billing

*Please fill out the Direct Debit Authorization (LSV+) / Debit Direct form and submit it to us as soon as possible.

We would like to draw your attention to the fact that the start of LSV+ debiting may be delayed by the filing of the LSV+ direct debit authorisation at the bank and might come into effect later than desired. Until the LSV+ direct debit authorisation is enabled, you will receive pay-in slips with which to pay premiums and out-of-pocket expenses.

Health-related information

Health declaration

1. Do you suffer from a disability or congenital condition? If so, please include a copy of the DI/IV ruling.	◯ Yes	◯ No
If so, what kind of disability / congenital condition?		
2. Are you currently receiving dental treatment or is such treatment planned?	◯ Yes	◯ No
If so, give the name and address of the dentist:		
3. When did the last dental check-up take place? (Note: If the last dental check-up was more than 1 year ago, a new check-up must take place.)		
Date		

Note for the applicant
You must have the enclosed dental certificate completed by a dentist with a Swiss federal qualification. The costs of the certificate, check-up and x-rays are to be borne by the applicant. Entitlement to benefits from the dental care insurance begins after a waiting period of at least 6 months after the insurance start date, as per GCI.

Conditions of insurance

By signing this document, (tick where applicable)

◯ I am applying to take out the aforementioned top-up insurance as per IPA/VVG (Insurance Policies Act).

– I acknowledge that this is not a request for a quotation, but a binding application to enter into an insurance contract as per IPA/VVG.

– I confirm that the information in this insurance contract and regarding health issues is complete, correct and truthful, and corresponds exactly to the facts – even if answers were written by the advisor or a third party.

– I authorise Visana Insurance Ltd to obtain and distribute from all medical professionals and/or other social and private insurers, authorities and Visana Group companies active in the insurance sector (Visana Insurance Ltd, Visana Ltd, sana24 AG, vivacare AG and Galenos AG) the information necessary to evaluate the application and I expressly release these named sources of information from the duty of professional secrecy and the obligation to maintain confidentiality in relation to Visana Insurance Ltd.

– I confirm that I have received the General Conditions of Insurance (GCI), Supplementary Conditions (SC) and/or Supplementary Conditions of Contract (SCC) pertaining to the insurance applied for, and that I accept these conditions.

– I acknowledge that the end of the employment relationship or termination of the membership of the association/society entails automatic reassignment from the collective insurance policy to the individual insurance policy in the following month.

– I agree that information regarding the top-up insurance taken out as per the Insurance Policies Act (IPA/VVG) can be digitally accessed by means of the insurance card.

I also confirm

◯ that I have received the information from the advisor as per art. 45 IOA/VAG;

◯ that I have received a copy of the consultation protocol from the advisor;

◯ that I have received the 'IPA/VVG Customer Information' sheet and (if Visana legal protection is applied for) the 'Customer Information on Legal Protection' sheet.

I hereby authorise

◯ Visana Insurance Ltd to pass on details of any exclusions/refusal to my advisor without disclosing health data.

Are there other current agreements pursuant to IPA/VVG for the duration of the products as per the application?

A copy of the previous insurance policy must be submitted with the application.

◯ I agree to any multiple insurance. I am aware that until the end of the insurance agreement, I shall therefore pay the premiums to my current insurer and to Visana.

◯ I hereby expressly consent to a postponement of the start of the top-up insurance insofar as necessary.

I am aware that Visana reserves the right to require a further health declaration and that in this case, the top-up insurance applied for may subsequently only be granted in limited form or even refused.

◯ The completed and signed consultation protocol is enclosed with the application for dental care insurance

Place, date

Signature

Advisor's surname, first name

Stamp and signature of advisor

No:

Place, date

Signature of the person to be insured or their legal representative

Dental health questionnaire

Insured person

Surname, first name | Date of birth

Address

Please answer every question!

1. When did the last dental check-up take place?
(If the last dental check-up was more than 1 year ago, a new check-up must take place.)

Date

2. Does the applicant suffer from an illness that affects / could affect the condition of teeth? ◯ Yes ◯ No

If so, what illness?

3. Have dental check-ups been conducted regularly in the past? ◯ Yes ◯ No

If so, at what intervals?

4. Is specific treatment planned? If so, when will it take place? ◯ Yes ◯ No

Date

5. Does the applicant suffer from tooth abrasion or erosion? ◯ Yes ◯ No
◯ Abrasion ◯ Erosion

If so, why?

6. Does the applicant suffer from misaligned teeth / a misaligned jaw? ◯ Yes ◯ No

If so, what is the nature of the misalignment?

Angle class: ◯ I ◯ II ◯ III

Is orthodontic treatment to be expected or has any already been started? ◯ Yes ◯ No

If so, what treatment and when?

Remaining cost in CHF:

Has suspicion of this been expressed? ◯ Yes ◯ No

If so, why?

When was the patient informed about this?

Date (If a cost estimate is available, please enclose this with the application.)

7. Does the applicant have carious teeth? ◯ Yes ◯ No

If so, please indicate which teeth.

55 54 53 52 51	18 17 16 15 14 13 12 11	21 22 23 24 25 26 27 28	61 62 63 64 65
85 84 83 82 81	48 47 46 45 44 43 42 41	31 32 33 34 35 36 37 38	71 72 73 74 75

8. Does the applicant have fillings? ◯ Yes ◯ No

If so, please indicate which teeth.

55 54 53 52 51	18 17 16 15 14 13 12 11	21 22 23 24 25 26 27 28	61 62 63 64 65
85 84 83 82 81	48 47 46 45 44 43 42 41	31 32 33 34 35 36 37 38	71 72 73 74 75

9. Has the applicant had root treatment on teeth? ◯ Yes ◯ No

If so, please indicate which teeth.

55 54 53 52 51	18 17 16 15 14 13 12 11	21 22 23 24 25 26 27 28	61 62 63 64 65
85 84 83 82 81	48 47 46 45 44 43 42 41	31 32 33 34 35 36 37 38	71 72 73 74 75

10. Does the applicant have teeth which have been damaged in an accident? ◯ Yes ◯ No

If so, please indicate which teeth.

55 54 53 52 51	18 17 16 15 14 13 12 11	21 22 23 24 25 26 27 28	61 62 63 64 65
85 84 83 82 81	48 47 46 45 44 43 42 41	31 32 33 34 35 36 37 38	71 72 73 74 75

11. Does the applicant suffer from periodontitis? ◯ Yes ◯ No

12. Does the applicant suffer from bleeding gums? ◯ Yes ◯ No

If so, why?

13. Does the applicant have gum pockets of 4 mm or deeper? ◯ Yes ◯ No

If so, please indicate which teeth.

55 54 53 52 51	18 17 16 15 14 13 12 11	21 22 23 24 25 26 27 28	61 62 63 64 65
85 84 83 82 81	48 47 46 45 44 43 42 41	31 32 33 34 35 36 37 38	71 72 73 74 75

14. Oral hygiene ◯ poor ◯ average ◯ good

The dentist signing below confirms that this questionnaire has been filled in truthfully. Answering questions incompletely or providing false information may lead to refusal to pay benefits, the addition of provisos or cancellation of the contract. The costs of the certificate, check-up and x-rays are to be borne by the applicant.

Place, date	Dentist’s stamp and signature