



## Resignation from the Collective Daily Cash Benefit for Sickness Insurance

### Insured person

Family name, given name

Date of birth

Street, No.

Sex: m  f

Postal code, Town

Nationality

Phone

Residence permit

Phone (business)

Profession

Cell phone

All the information you need about transferring to the individual insurance can be found in the following information sheet on our website: [www.visana.ch](http://www.visana.ch) > Firmenkunden > Service > Downloads > Merkblatt austretende Mitarbeitende (englisch)

### Declaration by the insured person

I am leaving/have left the company. per date \_\_\_\_\_

My employer's collective insurance contract has been/will be dissolved. per date \_\_\_\_\_

I am interested in continuing the insurance and would like to receive a no obligation quotation.

I do not wish to continue the insurance concerned.  
(In this case there is no need to answer any further questions; **please sign the form.**)

I would like to receive advice at no obligation. Best time to contact me \_\_\_\_\_

I intend to remain in the Collective Daily Cash Benefit Insurance

Please note: Until you are fully fit for work or until the maximum benefit period has been attained, you will continue to receive daily cash benefits for an existing condition. New illnesses are not covered. No premium is payable if you remain a member of the collective contract.

### Supplementary questions (only to be answered if you want a quotation to transfer)

1. Are you unfit for work/gainful employment?

No

If so why?:

Illness

Accident

2. Are you unemployed?

No

Yes

If possible include a copy of the first settlement/confirmation by the ALV

Yes

If so, do you have dependent children?

No

Yes

3. Do you have a new employment contract?

No

Yes, beginning \_\_\_\_\_

If so, does your new employer already have a collective daily cash benefit insurance?

No

Yes

4. Do you intend to work in a self-employed capacity?

No

Yes, beginning \_\_\_\_\_

My signature on the form confirms that I have been informed about my right to transfer to the individual insurance of Visana. I also verify that the statements made above are true.

Place, date

Signature of the insured:

Please use a ballpoint pen and write in capitals  
Page 2: Details of employer



### Insured person

Family name, given name

Town

### Details of employer

Name Company

Contact

Street, no. / P.O. Box

Phone

Fax

Postal code, Town

E-mail

### We require the following information if you wish to transfer to another insurance:

1. Date of joining the company per (date) \_\_\_\_\_
2. Resignation from the company per (date) \_\_\_\_\_
3. Did you have a temporary employment contract?  No  Yes
4. Annual salary insured (gross salary subject to AHV payments) CHF \_\_\_\_\_
5. Contract No. of Collective Daily Cash Benefit Insurance \_\_\_\_\_
6. Insured group (designation, if more than one) \_\_\_\_\_

Place, date

Stamp and signature

Please use a ballpoint pen and write in capitals

Please complete the form, sign it and send it to the address below:

**Visana Services AG  
Leistungszentrum Taggeld  
Weltpoststrasse 19  
3000 Bern 15**