## Helsana

## Application for DENTAplus Dental Care Insurance according to VVG

l	<b>-</b>	Name, surname								
	Date of birth	Address								
		Postcode, town, country								
	Legal representative for minors	Name, surname								
	Insurance from	Day	Month	Month		Year				
	DENTAplus insurance offer		<u></u>							
	Version	Age group	Premium		CHF					
	Discount		Net premi	um	CHF					
1	Health questions									
	Do you take/did you take medicine					□ Yes	🗆 No			
	regularly or were you prescribed to take any during the past 5 years? (Except birth control pill)	Yes, which o	nes?							
		From		to						
	Do you have a disability or congenital					□ Yes	🗆 No			
(	defect? (If yes, please attach a copy of the disability Insurance certificate)	Type of disal	pility or congenital de	fect						
- 3 /	Are you currently receiving/planning dental treatment?					□ Yes	🗆 No			
1		If yes, name and address of the dentist								
	How often do you visit the dentist for			□ 1 x per	per year 🛛 2 x per year					
(	check-ups?									
;     	How often do you have your teeth professionally cleaned?		□ Never	□ 1 x per	year	□ 2 x p	er year			
	How often do you have your teeth professionally cleaned?	be covered by the of 6 months from the above questions of nsurers, trust doctor ordance with the po- sment and for expla	gnised and qualified denti e applicant/person to be the start of the policy. ompletely and to the best of prs and other relevant office licies held by myself, in pair ination of any case of conc	st (or equivaler e insured. Clair of my knowledge s from their lega ticular their risk ealment of facts)	nt accordin ns may be and also t al or contra assessme ) in connec	ng to cantor e made unde that any answ actual duty of nt departmen ction with the	nal stipula- er the wers not w f confidenti nts, and en e requested			
	How often do you have your teeth professionally cleaned? Important The accompanying dental certificate must be filled out by tions or by a qualified dental hygienist). The costs of certification, check-up and X-rays must I DENTAplus Dental Care Insurance after a waiting period of With my signature I hereby confirm that I have completed the ten by me personally correspond to the details I have given. With my signature I hereby release service providers, health i ty towards Helsana affiliates as well as other insurers in acco ble them to provide the necessary information (for risk assess insurance policy. The Helsana Group comprises Helsana Insu For risk assessment and for clarification of any breach of the Helsana Group, and their partner companies in accordance w insurance file for basic and supplementary insurance and to the	be covered by the of 6 months from the above questions of mourers, trust doctor ordance with the po- sment and for explar rance Company Ltr disclosure obligati with the policy held use it to this end.	gnised and qualified denti- e applicant/person to be the start of the policy. ompletely and to the best of licies held by myself, in par- ination of any case of conc d, Helsana Supplementary I ons I hereby permit Helsana by myself, particularly their	st (or equivaler e insured. Clair f my knowledge s from their lega ticular their risk aalment of facts) nsurance Ltd an a Supplementary risk assessment	ant accordin ns may be and also t al or contra assessme ) in connec d Helsana / Insurance t departme	ng to cantor e made unde that any answ actual duty of nt departmen ction with the Accidents Li as Ltd, the m ents, to exam	nal stipula- er the wers not we f confidenti hts, and en requested td. embers of ine the hea			
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Helsana

## Dental questionnaire for DENTAplus Dental Care Insurance according to VVG

	Person to be insured	Name, surname							
		Date of birth							
	The costs of certification, check-up and X-rays must be covered by the applicant / person to be insured.	From the age of 7, x-rays (at least 2 bitewings) are required for clarification. These must be no more than 2 years old and will be returned following a finalized risk assessment. Please answer every question!							
1	When was your patient's last dental check-up? (Must be no more than 1 year ago)	Date							
2	Does your patient suffer from any illness that affects/could affect the condition of their teeth?	lf yes, please g	give detai	s		Yes	□ No		
3	Have cleaning and plaque removal been carried out?	If yes, how free	quently		□`	Yes	□ No		
4	Is treatment planned?					Yes	🗆 No		
		If yes, what and when is this planned							
5	Does your patient suffer from dental abrasion or erosion?	lf yes, what's t	he reasor	n for that		Yes	□ No		
6	Are your patient's teeth/jaw misaligned in any way?	lf yes, what typ				Yes	□ No		
7	Does your patient have any fillings?					Yes	□ No		
		lf yes, state co	ndition	□ poor	□ moderate		□ good		
8	Does your patient have any fixed or removable dentures?					Yes	□ No		
		lf yes, state co	ndition	□ poor	moderate		□ good		
9	Dental hygiene?			□ poor	□ moderate		□ good		
10	Condition of the gums? If available, please provide chart			□ poor	□ moderate		□ good		
11	Does your patient have any missing, unreplaced or partially formed teeth?	55 54 53 52 51	18 17 16	15 14 13 12 11	21 22 23 24 25 26 27 28	Yes 6'	□ No 1 62 63 64 65		
	If yes, please mark on this chart.	85 84 83 82 81			31 32 33 34 35 36 37 38		1 72 73 74 75		
12	Does your patient have any decayed teeth?				I .	Yes	🗆 No		
	If yes, please mark on this chart.	55 54 53 52 51	18 17 16	15 14 13 12 11	21 22 23 24 25 26 27 28	6	1 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	7	1 72 73 74 75		
13	Does your patient have any teeth that have undergone root canal work?				· □	Yes	□ No		
		55 54 53 52 51	18 17 16	15 14 13 12 11	21 22 23 24 25 26 27 28	6	1 62 63 64 65		
	If yes, please mark on this chart.	85 84 83 82 81	48 47 46	45 44 43 42 41	31 32 33 34 35 36 37 38	7	1 72 73 74 75		
14	Does your patient have accidentally					Yes	🗆 No		
	damaged any teeth?	55 54 53 52 51	18 17 16	15 14 13 12 11	21 22 23 24 25 26 27 28	6	1 62 63 64 65		
	If yes, please mark on this chart.	85 84 83 82 81	48 47 46	45 44 43 42 41	31 32 33 34 35 36 37 38	7	1 72 73 74 75		

The nationally-recognised and qualified dentist/ qualified dental hygienist (or equivalent according to cantonal stipulations) who signs this document confirms that it has been filled out accurately. Incomplete or false details can result in benefits being refused, reservations or cancellations of the policy.

X

Place and date

Stamp and signature of the dentist/dental hygienist



