Health declaration for Helsana Business Salary/Accident

○ New contract	Firm	
○ Policy changes	Postcode, town	
Contract no.	Beginning	Grouping
Person to be insured	Surname, first name	
○ male ○ female	Private address, street no.	
Date of birth	Postcode, town	
Income to be insured	CHF	Per year
Requested insurance cover	○ Illness ○ Accident	Social Security no. (AHV)

Each of the following questions must be answered personally by the applicant or their legal representative. The person to be insured can submit the completed form in a sealed envelope to the above-mentioned Helsana general agency for the attention of the medical risk assessment.

1. Have you taken out other insurances for loss of salary (daily allowance) in case of incapacity to work? If yes: ○ Yes ○ No

Insurer (except SUVA/UVG)		Amount in CHF			
	○ Accident ○ Illness		○ per day	○ monthly	○ yearly
	○ Accident ○ Illness		○ per day	○ monthly	○ yearly

Questions on illness and accident cover

2. a) Occupation in the above-mentioned firm — Which one?

Working hours h per week — Income CHF ○ monthly ○ yearly

b) Other gainful employment / other sources of income — Which one?

3. a) Are you currently unable or unfit to work and/or is a total or partial incapacity for work foreseeable? ○ Yes ○ No

If yes, to which extent (degree)? %

b) Did you have to interrupt your occupation (including work/housework/education) for a period of longer than 3 working weeks during the past 5 years? ○ Yes ○ No

If yes, please describe in question 10.

c) Do you have a disability or congenital defect, or do you draw an annuity or daily allowance? (e.g., from IV, MV, SUVA/UVG or other insurances) ○ Yes ○ No

If yes, which ones?

Since when? Disability degree: %

4. Have you suffered accidents in the last 5 years and/or do consequences and/or impairments resulting from an accident still exist? ○ Yes ○ No

If yes, please describe in question 10.

5. a) Do you drink or did you drink alcohol regularly (daily) in the last 2 years? ○ Yes ○ No

b) Are you a smoker? If yes, how much do you smoke per day? Since when? ○ Yes ○ No

c) Do you or did you take drugs? ○ Yes ○ No

If yes, which ones?

How often? from to

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Please see overleaf

Surname, First name **Date of birth**

6. Do you take or did you take medication* regularly (daily/weekly, longer than three weeks) in the last 5 years?If yes, which medication? (exact designation)
*except birth control pill

○ Yes ○ No

If yes, which ones?

from to

7. Physique (please give exact values, no approximate values)

Height (cm) Weight (kg)

Questions on illness cover

(If you are applying only for accident cover, you can skip the questions on illness cover.)

8. a) Are you receiving medical treatment/examination at the moment (physician, naturopath or therapist) or is it under consideration?

○ Yes ○ No

If yes, why?

b) Have you been advised to have a medical check-up/examination and not done so?

○ Yes ○ No

If yes, why?

9. In the last 5 years, have you had any medical/naturopathic/therapeutic treatment/check-ups/examinations either as an in- or outpatient for any physical or mental problems?

For example, because of illness or disorder:

a) of the respiratory system? ○ Yes ○ No

b) of the heart, the blood vessels, or the cardiovascular system? ○ Yes ○ No

c) of the psyche or nervous system? ○ Yes ○ No

d) of the digestive system? ○ Yes ○ No

e) of the urinary tract or reproductive organs? ○ Yes ○ No

f) of the skin or allergies? ○ Yes ○ No

g) of the muscles, bones, joints, or spinal column? ○ Yes ○ No

h) of the metabolism or endocrine system? ○ Yes ○ No

i) of the blood or infectious illnesses? ○ Yes ○ No

j) of the sensory organs (eyes, ears, nose) ○ Yes ○ No

k) Cancer? ○ Yes ○ No

If you answer one question with **Yes**, please give details in question 10.

l) any other illness/physical handicap/congenital defect not mentioned in the above list? ○ Yes ○ No

10. Further details (illness and accident)

If you answered one of the questions under 3b), 4 or 9 with «Yes», please give exact details.

Question	Type of illness/disorder (diagnosis) or accident, injured body part, type of complaint or result/reason of incapacity for work	Date from – to	Name and address of the physician/ naturopath, therapist/hospital	Cured with no aftereffects
				○ Yes ○ No
				○ Yes ○ No
				○ Yes ○ No

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Please see overleaf

Surname, First name **Date of birth**

11. Name and address of the physician who can best provide information about your state of health

Surname

Street, no.

Postcode, town

"I confirm that I have answered the above questions in full and truthfully. Incomplete or incorrect information is deemed a breach of the notification obligation**. This may result in cancellation of the contract or the exclusion of benefits."

In addition, if my insurance advisor completed the application on the spot on my behalf, I confirm that I have checked the information they provided and that this is complete and true.

By submitting the application, I release service providers, other social and health insurers, medical examiners and other competent bodies from their legal or contractual duty of confidentiality vis-à-vis the Helsana Group (Helsana Insurance Company Ltd, Helsana Supplementary Insurances Ltd and Helsana Accidents Ltd) and authorise them to provide the information required, primarily information relating to health and creditworthiness (for the purposes of risk assessment and to investigate any breach of notification obligation**) relating to the requested insurance policies.
I hereby authorise the Helsana Group to access and process any existing health insurance records related to daily sickness benefits insurance in accordance with the Federal Health Insurance Act (KVG) or the Federal Insurance Contract Act (VVG), basic insurance in accordance with KVG, and/or supplementary health insurance in accordance with VVG.

All data received is processed by the Helsana Group (PO box, 8081 Zurich) for the purposes of risk assessment and contract conclusion, as well as investigating any breach of notification obligation**.

You can find further information about data protection in our Privacy Policy at helsana.ch/data-protection.

** A breach of the duty of disclosure exists in particular if I provide incomplete or false information on the health declaration.

Place and date	Signature of applicant/legal representative	Signature of agent, if applicable