The Helsana Group comprises Helsana Insurance Company Ltd, Helsana Supplementary Insurance Ltd, Helsana Accidents Ltd and Progrès Insurance Company Ltd.

Helsana

Application for DENTAplus Dental Care Insurance according to VVG

Person to be insured | Name, surname

Date of birth | Address

Postcode, town, country

Legal representative for minors | Name, surname

Insurance from | Day | Month | Year

DENTAplus insurance offer

Version | Age group | **Premium** | **CHF**

Discount | **Net premium** | **CHF**

Health questions

1 Do you take/did you take medicine regularly or were you prescribed to take any during the past 5 years? (Except birth control pill) ☐ Yes ☐ No

Yes, which ones?

From to

2 Do you have a disability or congenital defect? (If yes, please attach a copy of the disability Insurance certificate) ☐ Yes ☐ No

Type of disability or congenital defect

3 Are you currently receiving/planning dental treatment? ☐ Yes ☐ No

If yes, name and address of the dentist

4 How often do you visit the dentist for check-ups? ☐ Never ☐ 1 x per year ☐ 2 x per year

5 How often do you have your teeth professionally cleaned? ☐ Never ☐ 1 x per year ☐ 2 x per year

Important
The accompanying dental certificate must be filled out by a nationally-recognised and qualified dentist (or equivalent according to cantonal stipulations or by a qualified dental hygienist).
The costs of certification, check-up and X-rays must be covered by the applicant / person to be insured. Claims may be made under the DENTAplus Dental Care Insurance after a waiting period of 6 months from the start of the policy.

With my signature I hereby confirm that I have completed the above questions completely and to the best of my knowledge and also that any answers not written by me personally correspond to the details I have given.

With my signature I hereby release service providers, health insurers, trust doctors and other relevant offices from their legal or contractual duty of confidentiality towards Helsana affiliates as well as other insurers in accordance with the policies held by myself, in particular their risk assessment departments, and enable them to provide the necessary information (for risk assessment and for explanation of any case of concealment of facts) in connection with the requested insurance policy. The Helsana Group comprises Helsana Insurance Company Ltd, Helsana Supplementary Insurance Ltd, Helsana Accidents Ltd and Progrès Insurance Company Ltd.

For risk assessment and for clarification of any breach of the disclosure obligations I hereby permit Helsana Supplementary Insurances Ltd, the members of the Helsana Group, and their partner companies in accordance with the policy held by myself, particularly their risk assessment departments, to examine the health insurance file for basic and supplementary insurance and to use it to this end.

Personal data are processed and stored in a database or kept on paper only for as long as expressly required by legal or contractual provisions as well as for reconsideration for an application that has previously been turned down. The personal data are then destroyed.

I hereby certify that before submitting this application I have received and taken note of the relevant insurance conditions (AVB/ZVB/VB/BVB) governing the supplementary insurance for which I have applied as well as the customer information according to the VVG, product sheets and – if the consulting has been carried out by a third person or Helsana employees – the information form according to the VAG of the insurance consultant.

I consent to receive via text message, e-mail, post or telephone regular information on products and offers from the Helsana Group that can be adapted to my individual requirements and hereby give my permission for the data to be used to this end. In addition, I consent to receive via text message, e-mail, post or telephone regular information on products and offers from partners of the Helsana Group, which are detailed on the Helsana website, and hereby give my permission for the data to be used to this end. I have taken note of the relevant data protection conditions on the Helsana website.
I have also received information on the partner companies of the Helsana Group listed on the website.

I am aware that I must inform customer services in writing should I wish to withdraw my consent of the use of my data for the above-listed marketing purposes.

Place and date

✗

Signature of person to be insured / legal representative

✗

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The Helsana Group comprises Helsana Insurance Company Ltd, Helsana Supplementary Insurance Ltd, Helsana Accidents Ltd and Progrès Insurance Company Ltd.

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?

☐ Yes ☐ No

If yes, please give details

3 Have cleaning and plaque removal been carried out?

☐ Yes ☐ No

If yes, how frequently

4 Is treatment planned?

☐ Yes ☐ No

If yes, what and when is this planned

5 Does your patient suffer from dental abrasion or erosion?

☐ Yes ☐ No

If yes, what's the reason for that

6 Are your patient's teeth/jaw misaligned in any way?

☐ Yes ☐ No

If yes, what type of misalignment

7 Does your patient have any fillings?

☐ Yes ☐ No

If yes, state condition ☐ poor ☐ moderate ☐ good

8 Does your patient have any fixed or removable dentures?

☐ Yes ☐ No

If yes, state condition ☐ poor ☐ moderate ☐ good

9 Dental hygiene? ☐ poor ☐ moderate ☐ good

10 Condition of the gums? ☐ poor ☐ moderate ☐ good
If available, please provide chart

11 Does your patient have any missing, unreplaced or partially formed teeth?

☐ 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	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

12 Does your patient have any decayed teeth?

☐ 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	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

13 Does your patient have any teeth that have undergone root canal work?

☐ 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	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 Does your patient have accidentally damaged any teeth?

☐ 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	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

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.

Place and date

✗

Stamp and signature of the dentist/dental hygienist

✗

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