Health declaration
Group daily sickness benefits insurance

Please answer the questions below by ticking the applicable box for "yes" or "no".

A Person to be insured

Surname _____

First name _____

Street/no. _____

Postcode/town _____

Date of birth _____ (Day/Month/Year)

Nationality _____

Gender ☐ male ☐ female

Have other insurers ever rejected an application or accepted it only under more onerous conditions? ☐ Yes ☐ No If so, why? _____

Please enter the name and address of your GP or the doctor who treated you last:

Name _____

Address _____

Telephone _____

If you answer yes to any of questions 2–6 or 11–13, please give further details in Part C or in the enclosure to the application form.

B Health declaration

1. Do you feel in perfectly good health? ☐ Yes ☐ No
2. **Have you been under doctor's care or medical supervision at any time in the last 5 years? Have you been treated by doctors, psychiatrists, psychologists, physiotherapists, chiropractors, naturopathic doctors, speech therapists, ergotherapists, or other healthcare specialists?** ☐ Yes ☐ No
3. Have you ever stayed or are you currently staying in a hospital, special clinic, sanatorium, spa or rehabilitation clinic? ☐ Yes ☐ No
4. Has outpatient treatment, an operation or a stay in a hospital/spa been planned or recommended for you? ☐ Yes ☐ No
5. Have you ever had an operation? ☐ Yes ☐ No
6. Are you experiencing the consequences of an illness or accident, do you suffer from a birth defect or disability, or do you have a medically diagnosed predisposition? ☐ Yes ☐ No
7. Body measurements: Height _____ cm Weight _____ kg
8. Have you ever been tested for HIV or hepatitis (hepatitis B, C)? ☐ Yes ☐ No

   If so, when? _____

   ☐ HIV positive ☐ HIV negative ☐ not tested

   ☐ Hepatitis positive ☐ Hepatitis negative ☐ not tested
9. Are you currently taking medication regularly or did you take medication regularly in the last five years? ☐ Yes ☐ No

   If so, which medication, how often, for how long and for which illness/symptoms?

Name of medication	Number per day	Duration	Illness or symptoms

10. Do you consume nicotine and/or do you or did you consume alcohol, drugs, or similar substances regularly? ☐ Yes ☐ No

If so, please indicate the units or number that you consume per day/week:

Nicotine (cigarettes, e-cigarettes, cigars, shishas, pipes)	Alcohol (1 unit = 1 dl wine, 3 dl beer, or 4 cl spirits)	Drugs (cannabis, marijuana, hemp and hashish, crack, ecstasy, hallucinogens, heroin, cocaine, LSD, opiates, speed, others)
What _____	What _____	Which _____
Number per day _____	Units of wine/beer per week _____	Number per day _____
	Units of spirits per week _____	From _____ to _____
	From _____ to _____	

11. Have you ever been injured in an accident? ☐ Yes ☐ No

Have you made a full recovery? ☐ Yes ☐ No

Are there any consequences which may still require treatment? ☐ Yes ☐ No

With whom were you insured against this accident? _____

12. Is your ability to work impaired at present? ☐ Yes ☐ No

Have you ever experienced a total or partial inability to work that lasted longer than 30 days? ☐ Yes ☐ No

13. Are you receiving or have you received insurance benefits from accident, military or disability insurance, a pension fund (BVG), or any other type of insurance? Or have you applied for such benefits (if so, please enclose decision)? ☐ Yes ☐ No

14. Are you pregnant? ☐ Yes ☐ No

If so, please indicate expected date of delivery. _____

C Additional information relating to the questions answered with yes in section B:

Question no.	Type of disease, injury, health problem	Start date	Duration	Fully recovered?	Treating physician (name and full address)
____	_____	_____	_____	☐ Yes ☐ No	_____
____	_____	_____	_____	☐ Yes ☐ No	_____
____	_____	_____	_____	☐ Yes ☐ No	_____
____	_____	_____	_____	☐ Yes ☐ No	_____
____	_____	_____	_____	☐ Yes ☐ No	_____
____	_____	_____	_____	☐ Yes ☐ No	_____

Special remarks:

Declaration by the undersigned

I hereby confirm that I have answered all the questions fully and truthfully and that even the answers that are not in my handwriting are an accurate reflection of the information I provided. I am aware that SWICA has the right to reduce or deny benefits, demand a refund of benefits it has paid, institute a proviso or benefit exclusion retroactively, or terminate the insurance with immediate effect if the health declaration or medical history proves to contain untrue or incomplete information. With my signature on this application I confirm having received and being legally bound by the General Insurance Conditions and the Supplementary Conditions. I hereby authorise SWICA and its insurance partners to obtain the information necessary for assessing the risk of the cover being requested from all medical and/or therapeutic personnel, from other insurers, as well as from companies in the insurance field within SWICA Group and release them expressly from their professional secrecy and non-disclosure obligations vis-à-vis the insurer while they evaluate this application and review the possibility of any violation of non-disclosure obligations. Furthermore, I authorise SWICA to forward the health declaration to the insurance carriers of the cover being requested for the purpose of reviewing the application, and I authorise them to inform SWICA of the respective decisions. I am aware and agree that information about myself can be shared within the organisational units of the relevant insurance carrier as well as among companies in the insurance field within SWICA Group. The undersigned can revoke this power of attorney at any time. The application for new cover or for a change in cover is deemed to have been accepted when I receive the insurance policy or written confirmation.

Place/date	**Signature of applicant**	Name and signature of advisory

Name and address of employer:

309e / online / 7.2018 / SW