Supplementary sheet

SWICA

Questions about health

Supplement to the «Health declaration for group daily sickness benefits insurance» form.

314e/ online / 1.2021 / SW

Person to be insured

Surname _____

First name _____

Date of birth _____ (Day/Month/Year)

Name of company/employer _____

Further details for column B

Question no. (column B): _____ Please provide the **exact** diagnosis, the exact disease and the body part affected:

_____

Which side is affected *(as applicable)* ☐ Left ☐ Right

Beginning: _____

Have you fully recovered from the illness without any consequences? ☐ Yes ☐ No

Do you still have symptoms or are you still undergoing treatment? ☐ Yes ☐ No
If no: Date of most recent treatment _____

Treating physician:

Practice/hospital _____ Name _____

Street/no. _____ Postcode/town _____

Question no. (column B): _____ Please provide the **exact** diagnosis, the exact disease and the body part affected:

_____

Which side is affected *(as applicable)* ☐ Left ☐ Right

Beginning: _____

Have you fully recovered from the illness without any consequences? ☐ Yes ☐ No

Do you still have symptoms or are you still undergoing treatment? ☐ Yes ☐ No
If no: Date of most recent treatment _____

Treating physician:

Practice/hospital _____ Name _____

Street/no. _____ Postcode/town _____

Special remarks:

_____

_____

_____

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