

Dental Application

Policyholder (premium payer)

Surname, first name

Person to be insured

Surname, first name

Sex: ☐ m ☐ f

Legal domicile

Nationality

Residence permit (enclose copy) ☐ C ☐ B ☐ L ☐ G ☐ Other:

Marital status

Requested insurance

Quote no.

Please note: The dentist's report (pages 2 and 3) must be completed by an accredited dentist who practises and is licensed to exercise the profession in Switzerland or a country neighbouring Switzerland (Germany, France, Austria, Italy or Liechtenstein). The application is only valid if not more than six months have elapsed between the last dental treatment or check-up and the date of the application. In addition, two bitewing X-rays (not more than six months old) bearing the name and date must be enclosed. The dentist's report and the X-rays are provided at the policyholder's (premium payer's) expense.

Children: The report and X-rays must be enclosed from January 1 of the year in which the child turns 7.

Important VVG/IPA terms

You'll find the terms of insurance and associated lists at www.sanitas.com/downloads/en

On signing this application

- I confirm that I have received, read and accept the general terms of insurance, the supplementary terms including associated lists, the special terms, customer information as per Art. 3 of the Swiss Federal Act on Insurance Contracts (VVG/IPA) and, if advised by an intermediary, the information form as per Art. 45 of the Swiss Federal Act on the Supervision of Insurance Companies (VAG/ISA).
- I confirm that the information about me on this application form, even if the responses were written down by a third party (representative), is complete, correct and truthful.
- the insurance carrier is authorised to provide information to doctors, dentists, medical facilities, other healthcare providers, social and private insurers and authorities or their company doctors and medical officers and to obtain from these parties any information necessary to assess insurance cover. In such cases, the parties in question are released from their obligation to maintain professional confidentiality and from their obligation of professional secrecy vis-à-vis the Sanitas Group.
- I confirm that, for the purpose of assessing insurance cover, particularly with regard to risk assessment and breach of the disclosure obligation, the insurance carrier is authorised to inspect any health insurance dossier that may exist in relation to basic and/or supplementary health insurance held with the Sanitas Group.
- I consent to checks being undertaken to assess my eligibility for cover under one of the insurer's framework agreements. I also undertake to notify the insurer immediately if I cease to be eligible for cover under such a plan. The discounts granted have been explained to me. In the event of a change or cancellation of the discount, I have the right to terminate the insurance contract in question with effect from the end of the calendar year within 30 days of receipt of the policy or notification of the amendment of the discount. This does not include temporary discounts.
- I agree to my data being forwarded and processed within the Sanitas Group for the purpose of claims processing, managed care and marketing.

Place and date:

Signature of the person to be insured or their legal representative,
guardian, or child and adult protection agency:

Name and address of legal representative:

Intermediary:

Stamp of partner company/broker:

Sanitas intermediary number:

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Dentist's report

1. The teeth of the person to be insured are currently in the following condition:

Restorative ☐ Good ☐ Poor

Endodontic ☐ Good ☐ Poor

Periodontal ☐ Good ☐ Poor

Orthodontic ☐ Good ☐ Poor

2. Does the patient have any dental prostheses? If yes, which type? ☐ No ☐ Yes

☐ Crown ☐ Good ☐ Poor

☐ Bridge ☐ Good ☐ Poor

☐ Implant ☐ Good ☐ Poor

☐ Prosthesis ☐ Good ☐ Poor

3. Does the patient have non-vital teeth? ☐ No ☐ Yes

If yes, please specify (enclose X-rays)

4. Are there any consequences resulting from a dental accident? ☐ No ☐ Yes

If yes, please specify

Date of accident:

5. Does the patient have any malocclusion? ☐ No ☐ Yes

If yes, please specify ☐ Distocclusion Class II ☐ Deep bite ☐ Mesiocclusion Class III

☐ Open bite ☐ Crowding ☐ Crossbite

☐ Other:

6. Is there any dental anomaly? ☐ No ☐ Yes

If yes, please specify

7. Are there any teeth missing with a closed row of teeth? ☐ No ☐ Yes

If yes, is there any dental tipping?

☐ No ☐ Yes (enclose X-rays)

8. Is the person to be insured currently undergoing treatment? ☐ No ☐ Yes

If yes, on what grounds?

9. Is any treatment planned or recommended? ☐ No ☐ Yes

If yes, on what grounds? When?

10. When did you last see the patient for dental treatment or a check-up?

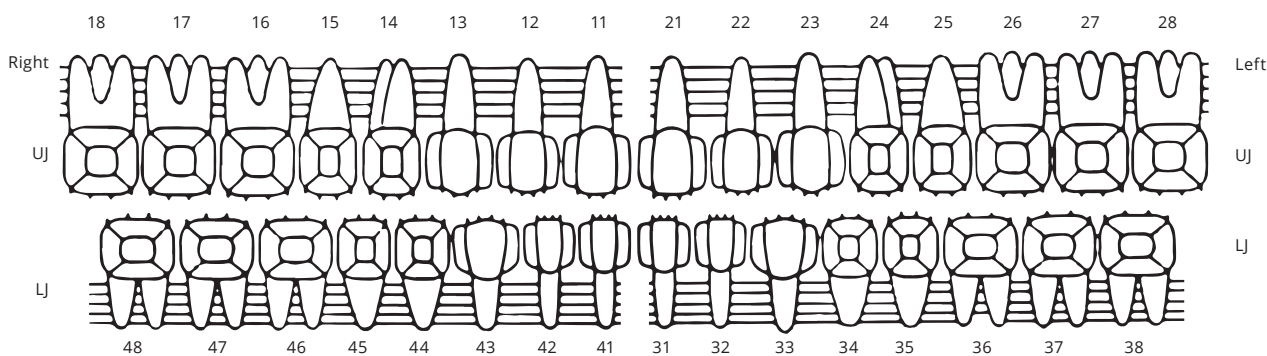
Application

Policyholder (premium payer)

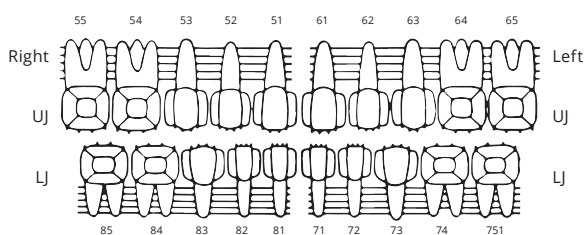
Surname, first name

Dentist's remarks:

Please mark the findings in the diagram with the relevant symbol:



Milk teeth:



- X Missing tooth
- Missing tooth with closed row of teeth
- ⊢ Filling
- Crown
- Bridge
- ⊗ Implant
- ^ Total prosthesis, upper jaw
- ∪ Total prosthesis, lower jaw
- ⌵ Partial prosthesis, upper jaw
- ⌴ Partial prosthesis, lower jaw
- D Non-vital tooth
- R Retained tooth
- ZK Tooth tipping
- O Decayed tooth

Have you answered all the questions in full and enclosed the relevant X-rays?

Place and date:

Stamp and signature of dentist: