sanitas

Application for

Insurance of dental

Policyholder (premium payer)
Surname, given name

Person to be insured
Surname, given name
Date of birth, sex
Civil law domicile

Desired insurance

☒ Quote no.

Additional information

Nationality	Residence permit (e.g. C, B, L or G; enclose copy)	Marital status

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 reaches age 7.

Important VVG/LCA terms
You'll find the terms of insurance at www.sanitas.com/downloads.

I hereby confirm that I have received and acknowledge the relevant terms of insurance (general terms of insurance, supplementary terms of insurance, special terms), customer information as per Art. 3 of the Swiss Federal Act on Insurance Contracts (VVG/LCA) 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/LSA).
I confirm that the information about me on this application form, even if the responses were written down by a third party, is complete, correct and truthful.
I hereby release doctors, dentists, treatment facilities and other medical professionals, health insurers and other competent bodies from their statutory or contractual obligation to maintain professional confidentiality vis-à-vis Sanitas group companies and other insurance carriers in relation to the insurance for which I have applied. I authorise them to provide information required to assess the risks and possible breaches of the disclosure obligation in connection with the insurance for which I have applied. In particular I authorise the insurance carrier to inspect any dossier that may exist in relation to basic and/or supplementary health insurance and to process the data.
I authorise the insurance carrier to assess my eligibility for cover under a group insurance plan. 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 and I understand that the loss of or a change in these discounts does not entitle me to terminate the insurance.
I agree to my data being used to the extent necessary in each case for processing claims, managed care and marketing purposes.

Place and date	
Signature of the person to be insured or their legal representative, guardian or guardianship authority	✘
Name and address of guardian	

Intermediary

Stamp of partner company/intermediary

Sanitas intermediary no.

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Dentist's report

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

Conservative	☐ Good	☐ Deficient
Endodontic	☐ Good	☐ Deficient
Periodontal	☐ Good	☐ Deficient
Orthodontic	☐ Good	☐ Deficient

2 Does the patient have dentures, dental implants or a dental prosthesis? ☐ No ☐ Yes

If so, what type?	State	
☐ Crown	☐ Good	☐ Deficient
☐ Bridge	☐ Good	☐ Deficient
☐ Implant	☐ Good	☐ Deficient
☐ Prosthesis	☐ Good	☐ Deficient

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

If yes, please specify. (enclose X-rays)

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

If yes, please specify.	Date of accident

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

If so, what type?		Other malocclusions
☐ Class II (distocclusion)	☐ Deep bite	
☐ Class III (mesioocclusion)	☐ Open bite	
☐ Crowding	☐ Crossbite	

6 Is there any dental anomaly? ☐ No ☐ Yes

If yes, please specify.

7 Are 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 treatment planned or desirable? ☐ No ☐ Yes

If yes, on what grounds?	When?

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

Date

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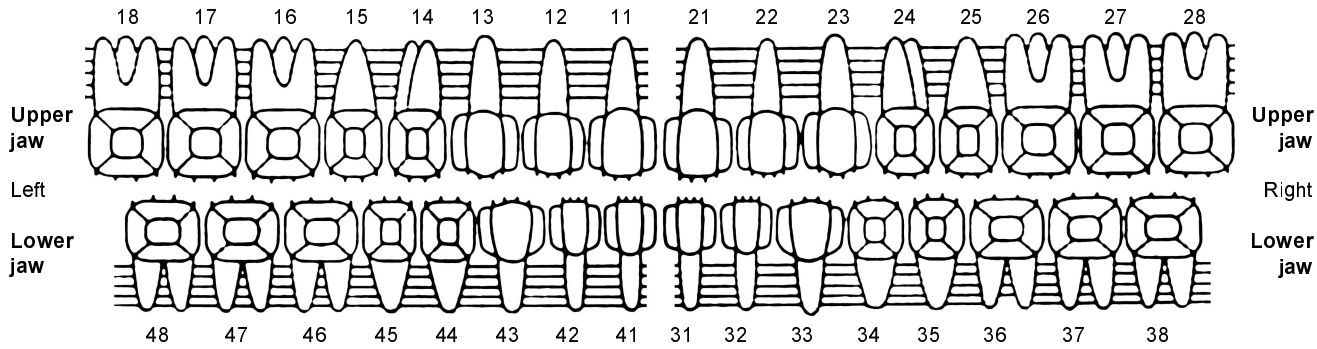
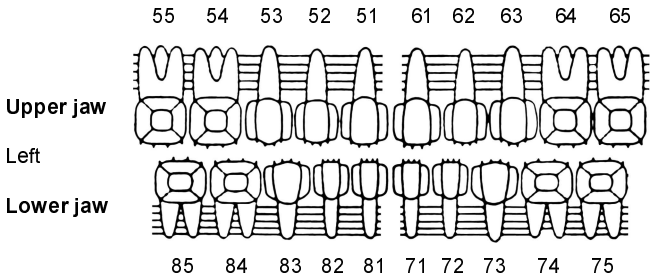
Dentist's remarks

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



X Missing tooth
Missing tooth with a 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 Dental tipping
O Carious tooth/defective filling

Milk teeth



Place and date

Stamp and signature of dentist

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