

# Illness-Related Death or Disability Insurance

## Notification for lump-sum payments



This form must be completed by the insured person or the insured person's legal representative. You can find all the information about the product and the required form at [css.ch/idd](http://css.ch/idd). Please complete the form in full and send it to us as quickly as possible to the address shown on the last page. Without your information, we are unable to review your entitlement to benefits. Thank you for your cooperation.

**If you are reporting a death, please ignore points 3.1, 3.2 and 3.3.**

**If you are reporting a disability, please ignore point 2.3.**

**Question 3.2 does not need to be answered for children younger than 15.**

Any questions? Our Contact Center will be happy to help on 0844 277 277.

Client number

Disability

Death

### 1 General information

#### 1.1 Details of insured person

First Name	Surname	Date of birth	Street address
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Postcode / town	E-Mail	Phone	Available at (time)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

#### 1.2 Details of person making report

First Name	Surname	Date of birth	Street address
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Postcode/town	E-Mail	Phone	Available at (time)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

### 2 Progression of illness

#### 2.1 Start of illness

Date on which illness began	Nature of illness / diagnosis
<input type="text"/>	<input type="text"/>

#### 2.2 Please describe the cause and the progression of the illness in as much detail as possible:

#### 2.3 Date on which death certified?

#### 2.4 Doctor/hospital/dentist providing treatment?

Name	Postcode/town
<input type="text"/>	<input type="text"/>

#### Other doctor/hospitals/dentists providing treatment?

Name	Postcode/town
<input type="text"/>	<input type="text"/>

Name	Postcode/town
<input type="text"/>	<input type="text"/>

2.5 Date on which treatment began?

2.6 Was this a pre-existing complaint?

Yes

No

If so, when did it begin?

### 3 Federal disability insurance (DI)

3.1 Are you already registered with the federal disability insurance (IV) scheme?

Yes

No

3.2 Are or were you unable to work as a result of the injury?

Yes

No

Degree of work incapacity in

% from

to

3.3 Was a pension granted?

Yes

No

### 4 Remarks

Please confirm these details with your signature. Many thanks for your support.

The undersigned person hereby confirms that he or she has answered all questions in this form truthfully and in full.

The undersigned person hereby assigns to CSS any liability claims arising from the illness referred to above up to the amount in benefits it has paid and acknowledges that CSS may assert its claims against third parties. By signing the illness notification form, the undersigned authorises CSS to share information and obtain such at any time from doctors, other service providers, social and private insurers and authorities, and its company doctors and medical advisors to the extent necessary to assess the insurance cover while respecting statutory provisions on data protection. In such cases, all parties involved are released from the obligation to maintain professional or patient confidentiality with respect to CSS.

The undersigned person has the right to request information about his or her data that is being processed. Consent to the processing of data may be revoked at any time.

The legal entity for lump-sum Illness-Related Death or Disability Insurance is Helvetia Swiss Life Insurance Company Ltd.

Place

Date

Signature of the insured person or his or her legal representative

Please return to:  
CSS Versicherung AG  
Special Insurance Competence Center  
P. O. Box 2568  
6002 Lucerne