Questionnaire for treatment abroad

For emergency treatments

This form must be completed by the insured person or their legal representative. All relevant questions must be answered in full and the signed form must then be returned promptly to the address at the end of the document. If you have any questions, our Customer Service Center will be happy to help on 0844 277 277. Thank you.

Client number

1 General information

1.1 Insured person

First name | Surname | Date of birth

Street, house number | Postcode/town

1.2 Contact

Home phone | Mobile phone | Business phone

What time is the best time to reach you? | Email

Where? Home ☐ Mobile ☐ Business ☐

2 Questions

2.1 Are you claiming for

☐ illness ☐ accident, please also complete the accident notification form in full ☐ maternity

2.2 Type of illness or injury

Exact description, type of illness or injury, or precise description of the event.

2.3 When and where did you suffer the illness or accident?

Date | Time

Place | Country

2.4 What treatment did you receive from the doctor or hospital abroad?

2.5 Duration of treatment

Outpatient treatment

Date

from to

Inpatient treatment

Date

from to

2.6 Costs of treatment

☐ CHF ☐ Foreign currency, which one

Outpatient treatment

	CHF	Foreign currency
Doctor's fees		
Medication		
Total		

Inpatient treatment

	CHF	Foreign currency
Hospital costs		
Medication		
Total		

2.7 Doctor/hospital providing initial treatment abroad or in Switzerland

First name

Surname

Hospital

Street, house number

Postcode/town

Country

2.8 Doctor/hospital providing further treatment abroad or in Switzerland

First name

Surname

Hospital

Street, house number

Postcode/town

Country

2.9 Had you previously received medical treatment for this ailment in Switzerland? ☐ Yes ☐ No

If yes, when and from whom?

Date

from to

First name

Surname

Street, house number

Postcode/town

2.10 Do you have any other insurance (illness/accident/transport costs/ETI cover note, etc.)? ☐ Yes ☐ No

If yes, with which insurance company?

Name of insurance company

Policy No. (please enclose copy of policy)

Street, house number

Postcode/town

Have you already reported the event to this insurance company? ☐ Yes ☐ No

2.11 Have you taken out separate travel insurance?

Policy no./application no.

With CSS? ☐ Yes ☐ No

With another insurance company? ☐ Yes ☐ No

If yes, with which insurance company?

Name of insurance company

Policy No. (please enclose copy of policy)

Street, house number

Postcode/town

2.12 Duration of and reason for stay abroad

Date

from to

2.13 Where is your legal place of residence?

Street, house number

Postcode/town

2.14 Have you deregistered at your last place of residence in Switzerland?

☐ Yes, as of ☐ No

2.15 For persons sent abroad by their employer: **When were you sent abroad by your employer in Switzerland?**

Name and address of employer

2.16 Details of benefit recipient

☐ Insured person ☐ Other recipient of benefits

First name

Surname

Client number

Street, house number/P.O. Box

Address supplement

Postcode/town

☐ Credit to account

IBAN

Name of your financial institution

2.17 Remarks

The undersigned person hereby confirms that they have answered all the questions on each page truthfully and in full.

By signing the questionnaire on treatment abroad, 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 secrecy or patient confidentiality with respect to CSS.

The undersigned person is entitled to request information about the data pertaining to them that is being processed. Consent to the processing of data may be revoked at any time.

Legal entity for basic insurance (KVG): CSS Health Insurance Ltd
Legal entity for insurance under the VVG: CSS Insurance Ltd

Place	Date	Signature of the insured person or their legal representative

Address of the insurance company:
CSS, Service Center, P.O. Box 2550, 6002 Lucerne

Form. 19e-03.25-pdf