Payment authorization with right of contestation

CSS

CSS Kranken-Versicherung AG
Mailroom
Tribschenstrasse 21
P. O. Box 2568
6002 Lucerne

LSV IDENT. CKU1W
RS-PID 41101000000612257

Premium payer

Customer no. _____ Date of birth _____

Last name _____ First name _____

Street, no. _____

Postcode, town _____

Please note:
We will notify you as soon as the direct debit has been set up. This can take up to six weeks.
Please pay any bills you receive during this time in the usual way.

Authorisation valid for
☐ Premiums only
☐ Co-payments only
☐ Premiums and co-payments

Debit **postal account**

I authorise PostFinance to debit the amounts due to CSS Kranken-Versicherung AG from my account in CHF. This authorisation will apply until revoked.

Please complete the payment authorisation form in full, sign it and send it to

- **CSS Kranken-Versicherung AG** (address at top left) or
- by email to **debitdirect@css.ch**

Debit **bank account**

I authorise my bank to debit the payments requested by CSS Kranken-Versicherung AG from my account in CHF. This authorisation will apply until revoked.

Bank name _____

Postcode, town _____

Please complete the payment authorisation form in full and send it to **your bank.**

Authorisation to debit my postal or bank account with right of objection
The amount debited will be refunded by my bank/PostFinance if I contest the payment in binding form within 30 days of the notification date.
If my account does not contain sufficient funds, the bank/PostFinance is not obliged to debit the account.
I will be notified each time my account ist debited, e.g. by account statement.

IBAN C H

Place, date _____ Signature/s* _____

*Signature grantor of power of attorney or authorised person for the account

Rectification (please leave blank, to be completed by the bank)

IBAN C H

Date _____ Bank's stamp and initials _____