KPT, PO Box, CH-3001 Bern
kpt.ch

Authorisation

Insured person (principal)

Policy no. ______________________________
First/last name ______________________________
Street/no. ______________________________
Postcode/town/city ______________________________

I hereby authorise KPT to issue the documents marked below to the private individual or company/institution indicated below and authorised by me:

- ☐ Insurance policy
- ☐ Customer magazine
- ☐ Premium bills, Premium reminders and outstanding amounts

Any unmarked documents will continue to be issued to the insured person indicated above.

If the authorisation relates to the following aspects, the identity of the insured person must be proven through the provision of a copy of an official identity document (passport, identity card etc.).

I hereby authorise KPT[1] to issue the documents/credits marked below to the private individual or company/institution indicated below and authorised by me:

- ☐ Benefit statements, dunning letters / outstanding amounts for co-payments
- ☐ All messages/correspondance: correspondence including medical documents and commitments to cover costs
- ☐ Premium refunds, to the authorised person's following account:
  IBAN C H _ _ ____ ____ ____ ____ _
- ☐ Benefit payments, to the authorised person's following account:
  IBAN C H _ _ ____ ____ ____ ____ _

Any unmarked documents will continue to be issued to the insured person indicated above.

[1] Depending on the insurance relationship with the insured person, KPT can mean KPT Krankenkasse AG (basic health insurance) and/or KPT Versicherungen AG (supplementary insurance).

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I hereby authorise the private person or company/institution indicated below to act on my behalf in my insurance matters with KPT[1], in particular:

☐ To make changes to my insurance, e.g. changes to cover, cancellation, new contract conclusion etc. (please check as applicable):

- ☐ In relation to basic health insurance
- ☐ In relation to supplementary insurance

☐ To issue and obtain information (please check as applicable):

- ☐ In relation to basic health insurance
- ☐ In relation to supplementary insurance

Sole authorisation to perform any unchecked tasks shall remain with the insured person and their legal representative.

Comments (e.g. specific restrictions on the issuance of information)

Details of the private individual to whom I issue authorisation

☐ Mr ☐ Ms

First/last name _____

Street/no. _____

Postcode/town/city _____

Telephone _____ Date of birth _____

Mobile no. _____ Email _____

Details of the company/institution to which I issue authorisation

Company/institution name _____

Contact person's first name/last name: _____

Street/no. _____

Postcode/town/city _____

Telephone _____

Email _____

[1] Depending on the insurance relationship with the insured person, KPT can mean KPT Krankenkasse AG (basic health insurance) and/or KPT Versicherungen AG (supplementary insurance).

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This authorisation applies from the date of signature until the date of written revocation.

Place and date _____ Signature _____
Policyholder

Place and date _____ Signature _____
Authorised representative

Please send the completed and signed form (together with a copy of an official identity document if necessary) to the following address: KPT, PO Box, CH-3001 Bern