Helsana

Power of Attorney

Valid for
○ Basic insurance in accordance with the Federal Health Insurance Act (KVG)
○ Supplementary Insurance(s) in accordance with the Insurance Contract Act (VVG)

Insured person - For identification purposes a copy of an official ID document must be included

Name, Surname

Street, no.

Postcode, Town/City

Insurance no.

Telephone

Email

Authorised person ○ Ms ○ Mr

Name, Surname

Street, no.

Postcode, Town/City

Date of Birth

Telephone

Email

I authorise the abovementioned person to receive the following information respectively take the following legal action in insurance-related matters involving the Helsana Group:

○ Information of any kind, including particularly sensitive data

○ Changing of personal details (e.g. surname, marital status, address, bank account)

○ Change in coverage (e.g. annual deductible, inclusion/exclusion of accident, change in GP/ basic insurance model)

○ Cancellation of insurance coverage

Change of administrative address required?
○ Yes, I hereby request that all correspondence (in particular premiums, insurance policies etc. as well as sensitive data such as benefit statements etc.) are delivered to the authorised person.
This is applicable within the scope of KVG and VVG.

Information for the authorised person
Are you insured with us and do you use the myHelsana client portal? If the answer is yes, you will receive all correspondence for the insured person digitally in your client portal or by post as well, depending on the communication channel selected in the portal.
○ No, I would like to receive all correspondence for the insured person by post only.

This power-of-attorney is valid as of the date of signature until such time as it is revoked in writing. I herewith unconditionally release the Helsana Group and all responsible employees from their duty of professional confidentiality, and their statutory duty of confidentiality vis-à-vis the authorised person appointed in this power of attorney.

Place and date | Signature of the insured person or their legal representative

Place and date | Signature of the authorised person

Please return the completed and signed form along with a copy of an official ID document of the authorising person to Customer Services: Helsana Insurance Ltd, PO Box, 8081 Zurich