CHANGING INSURANCE

# TERMINATION.

Please send this document to SWICA and not directly to your health insurer. We guarantee that it will only be forwarded if you are insured with SWICA unconditionally and in accordance with your wishes.

Your name and address

**Registered letter**
(Exact address of your current health insurance company)

Date of postmark

I hereby terminate my insurance plan(s) with your company with effect from _____ or the next possible date.

**Insurances to be terminated** (Check as appropriate)

Surname _____
First name _____
Date of birth _____ (day/month/year)

☐ KVG basic insurance as of _____
☐ VVG supplementary insurance as of _____
Ins. no. _____

Surname _____
First name _____
Date of birth _____ (day/month/year)

☐ KVG basic insurance as of _____
☐ VVG supplementary insurance as of _____
Ins. no. _____

Surname _____
First name _____
Date of birth _____ (day/month/year)

☐ KVG basic insurance as of _____
☐ VVG supplementary insurance as of _____
Ins. no. _____

Surname _____
First name _____
Date of birth _____ (day/month/year)

☐ KVG basic insurance as of _____
☐ VVG supplementary insurance as of _____
Ins. no. _____

Please do not try to persuade me to rejoin.

| Place/Date | Signature of insured person | Signature of spouse/partner | Signature of young persons above age 18 |
|---|---|---|---|
| | | | |

129a/online/9.2023

**THERE FOR YOU, 24 HOURS A DAY, 365 DAYS A YEAR.**
Phone 0800 80 90 80 / swica.ch

SWICA