Power of attorney

aquilana
Gesundheit für Generationen

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www.aquilana.ch

Particulars of the insured person

Surname _____ **First name** _____

Date of birth _____ **Insurance No.** _____

Street, No. _____ **Post code, place** _____

Home tel. _____ **Business tel.** _____

Email _____

Declaration granting a power of attorney

I hereby authorize the following person to act in my name in relation to Aquilana Versicherungen (here in after Aquilana) and in particular to perform the following actions in connection with my insurance matters:

☐ to obtain and / or provide personal and healthrelated information (including specific requests for documents such as policies, statements for services)

☐ to make changes to the insurance policies (including taking out / terminating products and signing / terminating contracts)

Administrative address for notifications

I instruct Aquilana to send all correspondence about my insurance relationship (premium and benefit accounts, policies, insurance card etc.) to the person holding a power of attorney named below.

☐ Yes ☐ No

The authorization to use the administrative address for notifications may be cancelled at any time and does not affect the validity of the power of attorney.

Particulars of the Person holding power of attorney

Surname _____ **First name** _____

Date of birth _____ **Email** _____

Street, No. _____ **Post code, place** _____

Home tel. _____ **Business tel.** _____

This power of attorney remains valid until it is cancelled in writing.

_____ _____

Place, date **Policyholder**

_____ _____

Place, date **Holder of power of attorney**

Please print out and sign the completed form. Then send it to Aquilana. Thank you very much!