aquilana
Gesundheit für Generationen

Grant of a power of attorney to handle the change of insurer to Aquilana as of

☐ I/we instruct Aquilana to process and perform the administrative tasks, in particular giving notice to the previous healthcare insurer, for the transfer to Aquilana as of . This power of attorney remains valid until it has been cancelled by the person(s) who grant(s) the power of attorney:

1. Personal particulars and address of the insured person (Head of family / Policyholder)

Title ☐ Mrs ☐ Mr

Surname

First name

Address

Post code / place

Date of birth

Gender ☐ M ☐ F

ABB personnel No.

☐ The authorisation given above for the change of **insurer,** in particular to **terminate the insurance policies as of** **,** and the grant of a power of attorney likewise apply to the persons named below.

2. Personal particulars of partner, family members (in same household)

Surname	First name	Date of birth	
			☐ Termination of insurance
			☐ Basic insurance KVG ☐ Supplementary insurance VVG
			☐ Basic insurance KVG ☐ Supplementary insurance VVG
			☐ Basic insurance KVG ☐ Supplementary insurance VVG
			☐ Basic insurance KVG ☐ Supplementary insurance VVG
			☐ Basic insurance KVG ☐ Supplementary insurance VVG

Place, date

Signature of policyholder

Signature of all adult persons

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