HOSPITALIZATION

CHANGE OF OPTION

I, the undersigned : Name : .... First name :...

Street : .... Nr. : .... Box : ...

Postal code : ....… City : ....

Telephone : .... E-mail : ....

National registration number : ....

Financial account (IBAN) : __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __

Please affix a sticker from your mutual health insurance company

Request the modification of my optional hospitalization insurance

Starting from : _ _ / _ _ / _ _ _ _

☐ to Neutra Base ☐ to Neutra Optimum ☐ to Neutra + ☐ to Neutra Comfort ☐ to Neutra Top

I am aware that this modification will apply automatically to all the people who are included in my contract to this date.

Drawn up on _ _ / _ _ / _ _ _ _ in ....

Signature of the policyholder : ....

TO FILL IN IF A COUNSELOR OF YOUR MUTUAL HEALTH INSURANCE COMPANY GAVE YOU ADVICE

DUTY OF INFORMATION

FORM FOR A HOSPITALIZATION INSURANCE (No-Life)

Member data : I the undersigned : Name : ……………………………………………………… First name : ………………………

What are your needs and expectations ?

Coverage for hospitalization fees :	☐ Reimbursement of the real cost	☐ Flat-rate reimbursement
Coverage in case of serious illness :	☐ Yes	☐ No
Coverage in private room :	☐ Yes	☐ No
Coverage for dental care :	☐ Yes	☐ No
Coverage abroad :	☐ Yes	☐ No

What's your current situation ?

Already subscribed to a hospitalization insurance : ☐ Yes ☐ No

Family situation :	☐ Single	☐ Couple	☐ Children (number : ………)
Available income :	☐ High	☐ Medium	☐ Low

Written proof of the advice :
Based on the above mentioned information and in an effort to avoid each form of over-insurance, under-insurance or inadequate coverage, **we recommended our member to subscribe to the following product**:

……

The member chose : ☐ Neutra Base ☐ Neutra Optimum
☐ Neutra + ☐ Neutra Comfort ☐ Neutra Top

The member expressly acknowledges that he has accurately represented all circumstances known to him that might influence the advice given by NEUTRA Mutual Insurance Company. The member also acknowledges that the content of the insurance contract that he chose corresponds to the analysis of his needs and requirements and that he was informed on the range and limits of this contract.

☐ I acknowledge that I have been informed on the capacity of the counselor.

Done in two copies, one of which is passed on to the member.

Drawn up on __ / __ / ____ in ……………………………………………………………………………………………………

Signature of the policyholder :
« Read and approved »

Name and first name of the counselor : ………………………………………………

Acting as : ☐ person in contact with the public at Symbio
☐ responsible for distribution at Symbio

……………………………………

Signature of the counselor :…………………………………………………………