groupemutuel

# Invoice regrouping as from _____

## Client 1: policyholder

Name: First name:

Date of birth: Client No.:

## Client 2:

Name: First name:

Date of birth: Client No.:

## Children

| Name and first name | Client No. | Date of birth | Invoicing regrouped with | |
|---|---|---|---|---|
| | | | Client 1 ☐ | Client 2 ☐ |
| | | | Client 1 ☐ | Client 2 ☐ |
| | | | Client 1 ☐ | Client 2 ☐ |
| | | | Client 1 ☐ | Client 2 ☐ |

## To which address should the joint invoices be sent?

Name: First name:

Street/No.: P.O. box:

Postal code: Place:

## Bank/PostFinance:

Account holder:

Bank/PostFinance : IBAN/Account No.:

Clearing No.: Postal code/Place:

Place and date :

Signature client 1: Signature client 2:

## Important information:

Invoice regrouping cannot be requested for a date prior to the date on which this form is signed. If the regrouping date is not indicated above, the regrouping will be scheduled for the next billing date.

By signing this form, insured adults agree that all communications, premium invoices and statements of benefits will be sent to the invoice recipient indicated on this form, and agree that the invoice recipient will have access to all contract data, including data relating to medical care and state of health.

Invoice regrouping applies only to spouses, registered partners, cohabitants or minor children up to the age of 18. Only persons insured with the same insurer may have their invoices regrouped.

**Document to be returned to Groupe Mutuel - Rue des Cèdres 5 – PO Box - CH-1919 Martigny**