insureme

New in Switzerland

A guide to the health insurance system in Switzerland.

Content

Introduction

This brochure is intended to help people who are newly arrived in Switzerland to make sense of the health insurance system and clarify the questions most frequently asked by new residents in Switzerland.

Picture 1: Not to see the wood for the trees

This brochure will give you an overview of the health insurance system in Switzerland and explain the difference between compulsory insurance (a.k.a. basic insurance) and supplementary insurance. It will explain what coverage is offered by both insurance types and what premium insurance includes.

However, it must be pointed out that this document can only provide a general overview of the legal requirements by hinting at main points. Every person is unique in their own wishes and needs.

For an individual consultation, you may contact the issuer of this booklet (see page 17).

Compulsory or basic insurance

The “Grundversicherung” (literally “basic insurance”) is also known as “compulsory health insurance” under the Health Insurance Act, is required by every Swiss resident and/or any person working for a company based in Switzerland. Whether you are a new resident in Switzerland (including new-born) or a worker, you must sign an insurance contract within three months upon registration in Switzerland (or respectively, upon birth).

We do not recommend prolonging this task until the last minute, as the premium must be paid in advance and is due from the date of registration. This means that the payment will also have to be paid retrospectively. For the unborn child, we even recommend signing an insurance contract during pregnancy, before the birth (more details on page 10). If a contract is not signed within three months, a surcharge will be issued, and any health related expenses will not be reimbursed.

In order to sign a contract, your residence permit (Aufenthaltsbewilligung) is needed. If you do not have one yet, you may ask your local municipality for a letter confirming your address (Wohnsitzbestätigung), which is, in most cases sufficient. Nevertheless, you must provide proof of a valid permit as soon as have it.

If you are already insured by a Swiss operator, you may provide a copy of the former policy to apply for a new one.

Coverage

In general, compulsory health insurance covers all treatment carried out by a physician, inpatient or outpatient. Should any treatment not be covered by this insurance, the patient will be informed prior to a procedure.

Compulsory insurance also covers a range of other services prescribed by a physician or other health professionals. Your health insurer will inform you as to whether a service is covered or not if you have any doubts. Bear in mind that you must follow the rules according to the type of insurance you have chosen (if you have chosen other than the standard model). If not, the insurance company has the right to reject your claim or to transfer you to the standard model, which means you pay a higher premium.

Concerning **complementary medicine**, the compulsory health insurance covers five types of complementary therapy including acupuncture, anthroposophical medicine, traditional Chinese medicine (TCM) pharmacotherapy, classical homoeopathy, phytotherapy/modern herbal medicine) if they are executed by a qualified medical specialist. Those physicians may be found here:
www.medregom.admin.ch/EN
Physiotherapy is covered if prescribed by a physician and carried out by a registered physiotherapist.

For **inpatient treatment in a hospital**, you can only go to a hospital listed in your canton of residence unless it is an emergency or a special treatment which cannot be treated in the hospital of your canton. In any case, you have only coverage for the general ward. If you wish to have a free choice of hospitals in

Switzerland, you will need supplementary insurance. Also, you can have coverage for the semi-private and private ward with supplementary insurance. This gives you various advantages (read page 8).

Medicines are covered if they are prescribed by a physician and included in the list of pharmaceutical specialities. The list consists about 2'500 medicines and is regularly updated. If the ingredients are included in the list of tariffs, even extemporaneous preparations produced at pharmacies are covered.

Compulsory insurance not only covers treatments for existing issues but also **preventative measures**, such as various vaccinations, the health and development of children, gynaecological screening examinations, mammography, screening for cancer of the colon, etc.

Up to the age of 18, compulsory insurance contributes 180 CHF per year for **spectacles and contact lenses** if prescribed by an ophthalmologist. Only in serious illnesses does basic insurance provide coverage regardless of age and the contribution can be higher. Supplementary insurance can provide coverage of up to 300 CHF per year for minor illnesses.

Dental treatment is only covered for serious disorders of the masticatory system. Braces, teeth filling etc. are not covered by compulsory insurance. With certain supplementary insurance, it is possible to get coverage of up to 100% for orthodontic treatment.

If you need coverage for **medical transport and rescue,** the basic insurance is very limited. Transport (e.g. an ambulance) can easily cost 2'000.– CHF per transport, and compulsory insurance only covers 50% of costs (up to 500 CHF per year), and only in Switzerland. In case of a rescue event, it is also covered by 50% (up to 5'000 CHF), and again, only in Switzerland. Since this is very insufficient coverage, we recommend an outpatient package of supplementary insurance.

Coverage abroad is very important for people new to Switzerland, since they may wish to travel to their home countries. Often, they also work in an environment where they must travel a lot for business reasons. If you have an urgent problem which cannot wait to be treated until you travel back to Switzerland, you are covered by basic insurance. What is essential to know is that **inside the EU/EFTA states** you can enjoy the same coverage as a resident of the country you stay. It might be that a local organization pays for the treatment and they later invoice the insurer in Switzerland, or that the patient pays in advance and requests reimbursement later from the insurer in Switzerland. **Outside the EU/EFTA states**, the insurer only covers twice the amount that would be reimbursed for the same treatment in Switzerland. For inpatient treatment, this means the coverage is up to 90%. For certain countries where the treatment costs are usually higher than in Switzerland, this coverage is insufficient. But it can be improved by supplementary insurance, which covers an unlimited amount for a full year.

Premiums

The premiums are at a reduced price for children up to 18 years. Adults between the age of 19 and 25 can also avail of a reduction. The premium is not influenced by income, however, every insurer sets different **prices depending location of residence, age, deductible, type of insurance and whether accidental**

insurance[1] needs to be included or not. For families with a very low income, there is a possibility for a premium reduction offered by the state (read more on page 14).

Co-payment

In most cases, the insured person must contribute to their health bill. There are two elements:

- A **deductible** of 300 CHF up to 2'500 CHF — for children 0 CHF up to 600 CHF.
- A **retention fee** of 10% limited to 700 CHF per year — for children up to 350 CHF.

For example, if you choose a deductible of 300 CHF and receive a medical invoice of 1'000 CHF, you pay the 300 CHF deductible and 10% on the remaining 700 CHF. In total 370 CHF.

What must be considered is that the premium varies depending on what deductible you have chosen. The difference between the highest and the lowest will change the price by 120 CHF per month. Therefore, we recommend choosing a high deductible if you generally have health costs lower than 1'740 CHF per year. And if your average costs are higher, you benefit more by choosing the lowest deductible.

The deductible does not apply to maternity-related services, mammographies, and screenings for cancers of the colon.

Models of insurance

In the standard model, you can choose freely which doctor you wish to visit throughout Switzerland — regardless of whether it is a general practitioner or specialist. This type brings with it a lot of costs because people go unnecessarily to a specialist where a general practitioner could have provided a better and cheaper consultation. Therefore, several types of insurance have been created.

By opting for a **general practitioner model**, you must always first consult your chosen general practitioner. He/she will then decide whether or not you need to be referred to a specialist or for hospital treatment.

Similar to this model is the **HMO (health maintenance organization)** model, where you go first to your chosen practice where you are registered. With this model, you may not always be seen to by the same doctor at the practice. However, he/she will refer you to a specialist if needed (as in the general practitioner model).

Since not every physician is fluent in English or other languages than our national languages, the **Call-Med model** is a good choice as well. In this model, you first call a hotline where medical personnel will answer your call. You can describe your issue, and they will refer you to a general practitioner or a specialist. The big

[1] If a person works more than 8 hours per week, by law it is insured by the employer. If less or jobless, the option needs to be activated at the insurer. Usually, a phone call is sufficient for that.

advantage besides the language is, the service is available 24/7 and you have a free choice of which doctor you wish to visit after.

Other models also exist, such as a **pharmacy model**, where you go to a pharmacy for a first consultation — which we do not recommend. A pharmacist simply does not have the same expertise as a physician. Also, there are **mixed models** where you can choose between the models, depending on what you prefer at any given time.

Important: Some cases exist where you do not have to follow the above rules for the first consultation. These are emergencies, visits to the ophthalmologist, and gynaecologist.

The Federal Office of Public Health publishes a list[2] of all the possible options where you live, taking your age and your wishes concerning deduction and accidental coverage into account. However, there is no guarantee that you have the choice of any model because it also must be taken into consideration whether your general practitioner/HMO-practice has free space to accept new patients, or the next best practise is 20 or 30 km far away. Therefore, it may happen that you cannot pick the cheapest offer but the sixth cheapest because only there you can choose an appropriate place for a consultation.

Also bear in mind that if you choose supplementary insurance as well, it is very likely an insurance company offers cheap basic insurance but expensive supplementary insurance and vice versa. It is important to consider mainly the benefits in case of supplementary insurance and not (only) the premium.

Rules of the various insurance types

Tiers garant vs. tiers payant

Compulsory insurance companies offer two types of refund system. In the "tiers payant" system, invoices issued by physicians, hospitals or pharmacies, are sent directly to the insurance company. The insurer checks the invoice. If the deduction is not paid yet fully, the policyholder will receive an invoice by the insurer for the same amount. If the deduction is paid fully, the policyholder only pays the retention fee of 10% up to 700 CHF (children 350 CHF) per year. If the retention fee is paid to the fullest already, the insurer covers all the costs.

The "tiers garant" system is much less convenient. The policyholder receives the invoice directly and needs to check the content and pay the amount by themselves. After paying the invoice the policyholder can hand in the invoices and claim for a refund. As you might imagine, in this system a policyholder needs much more capital, since the policyholder has to perform an advancement. Some companies even do not allow a claim during the year, but only at the end of the year.

[2] *https://www.priminfo.admin.ch/de/praemien*

For any inpatient treatment, the tiers payant system is used.

Medicine

If you have chosen a certain type of insurance other than the standard model, whenever possible, your doctor will prescribe less expensive generic medicine. This medicine contains the same ingredients as the original product. In the standard model, you may choose the original product.

The first point of contact

In all types of insurance, you have a mandatory first point of contact. In the general practitioner model, it is your chosen family doctor. In the HMO model, it is the chosen practice. In the pharmacy model, it is a certain pharmacy. After this first contact, you have to follow the advice given by the first contact.

Depending on the call-med model, different insurance companies will have different rules. Sometimes one company will even provide two or more different call-med models with different rules. In some models, after consulting the hotline, you are free to choose what doctor you visit. In others, you are obliged to follow the instructions given by the hotline doctors. This means if they tell you that you should visit a general practitioner, you are not allowed to go to a specialist, or if they recommend taking some medicine from the pharmacy, you are not allowed to go to a physician. But in general, the personnel on the hotlines deal with patients with great care. They will rather advise you to visit a physician than take the risk of prohibiting a visit and be responsible for the consequences of a poor consultation. The reference to a physician usually lasts 30 days. If your treatment is not over, you can extend this period by a call or in the app of the hotline.

Keep them posted

If you are referred to a specialist as your first point of contact, you usually do not have to inform the insurance company nor the first point of contact, since the communication runs automatically. As for the call med model you need to inform the hotline if the doctor you agreed to visit refers you to another physician. You can do it by calling the hotline or using the hotline app and registering the additional doctor to your registered treatment.

Supplementary insurance

As you have read in the previous chapter, compulsory insurance already covers the major areas. Nevertheless, for some areas, the coverage is too low or even inexistent. Most Swiss residents have supplementary insurance of some sort. This is mostly because the extra costs are rather low in comparison to the compulsory insurance, and the benefits are much higher.

While compulsory insurance must accept everyone applying for it (regardless of level of health), supplementary insurance has the right to choose who they accept. A questionnaire must be filled out which gives information about your health status. If you have a relevant issue, the insurance company may accept you with the exclusion of some benefits or reject you completely. If you are offered this insurance with some exclusion, you are free to choose to accept this or not.

It is important is to bear in mind that even if you consider supplementary insurance as unnecessary now, you will not be able to acquire it on demand when you need it. People often think when they hear they must proceed with a certain treatment or execute a surgery, that they can apply for supplementary insurance which will cover the costs. This is not the case. An insurance company will always reject this kind of application.

Also, you are obliged to declare your health status correctly. If you do not and the health insurance finds out, they will cancel the contract, and reclaim all provided services.

Supplementary insurance is privately organized and every insurance company has different benefits. Our company is specialized in comparing the advantages and downsides of the coverage but also of the companies.

Coverage

Outpatient treatments

This package provides a wide range of coverage. Whereas you can visit doctors only in your canton of residence, with the outpatient package you can visit doctors throughout Switzerland. This can be very useful if you need to visit a specialist who practices in another canton.

Medication which is not subject to the basic insurance can be covered in this package as well. There are always new products on the market which are more effective, but they are not (yet) recognized by compulsory insurance. Most supplementary insurance covers these drugs with up to 90% for an unlimited amount. Considering, for example, a cancer therapy, where a pill can cost many thousand Swiss Francs, this can be a precious benefit.

As already mentioned in the previous chapter, emergency transport, including search and rescue events are insufficiently covered by compulsory insurance. With the outpatient package of supplementary insurance those events are covered up to 100'000 CHF per year.

In case of an illness abroad where you cannot wait to travel back home to Switzerland, (e.g. abdominal pain), most supplementary insurance covers the medical expenses completely.

Where spectacles and contact lenses are normally not covered for adults, you can have coverage from 150 CHF every three years to up to 300 CHF per year with this coverage. (This varies heavily depending on the insurance company.)

Complementary medicine & physiotherapy

Often people would like to avoid conventional pharmaceutical drugs, especially for small children. Most insurance companies offer natural healing treatment and alternative medicine which includes over 70 different methods. For adults, it makes sense especially for minor chronic illnesses.

Inpatient treatments

It makes sense to take out semi-private (or private) hospital insurance if you wish to have access to the best doctors and hospitals, including most experienced surgeons. It also means that you will not have to wait unnecessarily long for an operation appointment. There are also so-called "Flex models", where you can decide, before entering a hospital whether you wish to go to a general ward, a semi-private ward or private ward.

Dental treatments

We consider dental insurance only for children due to the premiums. If you miss the right time to sign up for a contract you will bear the costs for expensive dental treatment and/or braces on your own. Most insurance companies ask for a dental certificate from the age of three. Only a few will not ask for it at a higher age.

For the dental certificate, a dentist has to approve the status of the teeth and take x-rays. If the dentist attests an issue, the insurance company will make an exclusion or in the worst case reject the application.

The following benefits are usually paid for by dental insurance:

- orthodontics
- x-rays
- fillings
- check-ups
- tooth extractions (e.g. removal of wisdom teeth)
- dental hygiene
- pivot teeth
- bridges
- prostheses
- crowns

Accident insurance

For all the single supplementary products, you have the possibility to opt-in for accidental coverage. This is useful because the coverage which your employer offers might only cover a general ward and other positions like basic insurance. If you use the option to have also covered accidents on the supplementary products, you enjoy the same benefits you have with your personal health insurance.

Insurance against death and disability due to accident and illness

Adults are mostly covered for accidents through employers if they work more than eight hours per week. If not, they must activate the coverage with their compulsory health insurance.

The 1st and 2nd pillar (AHV and BVG) of the social insurance system in Switzerland pay in case of death or disabilities (not only for accidents, but also in case of illness). Nevertheless, it is possible to obtain additional coverage for a certain amount, which can be defined in the application.

Children are obligatorily insured against accidents through basic health insurance. The consequences of illness, on the other hand, are not insured for children. However, since this is much more common than an accident, it is advisable to include coverage for your child for this risk.

Many health insurance companies offer appropriate insurance to cover financial damage resulting from disability or death. For example, you can choose coverage of 200'000 CHF in the event of disability and 20'000 CHF in the event of death.

Premiums

The inpatient and outpatient packages are considered as a very good top-up on basic insurance. The prices start from approximately 15 CHF to 20 CHF per month. These prices rise depending on the range and type of your coverage.

Complementary medicine is worth it for those who need it. Prices can start very low. On average, it starts from about 20 CHF month. Prices can rise here as well, depending on the coverage.

Coverage for dental issues is rather expensive for adults. We do not recommend any solution for adults, because the premiums are often almost as high as the coverage. For children, on the other hand, the prices are reasonable. Depending on the age it starts from about 2 CHF per month.

The accident insurance costs just a few Swiss Francs per product. Since the coverage of employer can be and mostly is limited you always profit from including this.

Prenatal application

The prenatal application describes the registration of an unborn child for health insurance. The insurance policy is activated by the insurance company at the time of birth, so your baby benefits immediately from the desired insurance protection from birth.

A pregnancy without complications normally lasts 9 months. However, unexpected premature births can also occur, so it is recommended to care for the insurance solution of your unborn baby as early as possible — but at the latest from the 7th month of pregnancy. This way you prevent the lack of insurance protection in the event of premature birth. If you register your baby before the birth, the health insurance provider will include it in the supplementary insurance without any health check. This means that when the baby is born, even in the event of a birth disorder, it has the best possible insurance cover.

Important: The premium is only payable from birth. Despite the prenatal registration, the premium for baby insurance is only due from birth. It doesn't matter whether you insure your unborn baby in the first month or from the 7th month of pregnancy.

Advantages of prenatal registration via insure me:

- Save the administrative effort after birth.
- Your baby is insured from birth, even if it is born sick or is born prematurely.
- Your unborn child is registered with the health insurance company before birth and without any health issues. Insurance must provide cover. If you only take care of it after the birth, a health declaration is necessary and the health insurance company can reject additional insurance without giving reasons since there is no obligation to admit.

Maternity

The basic insurance benefits are the same for all Swiss health insurance companies. In the case of supplementary insurance, however, these can differ massively. The health insurance companies have a waiting period of 270 to 365 days for supplementary insurance benefits, so no maternity benefits are paid for up to 365 days after the start of the supplementary insurance. If you do not have any additional insurance yet, we recommend that you sign up at least one year before your planned pregnancy.

Compulsory insurance

The following benefits are covered by compulsory health insurance before birth.

- Two ultrasound exams
- 7 check-ups by doctors/midwives
- Laboratory analysis
- Two pairs of compression stockings prescribed by a doctor
- CHF 150 for midwifery preparation courses and counselling sessions

Important: In the event of a high-risk pregnancy, more ultrasound and check-ups are paid for by the health insurance company, depending on the medical need.

Below you will find a list of the most important services that your health insurance provider will take on during and after the birth.

- Birth costs of the general hospital ward in the canton of residence, at home or in a birthing centre
- In emergencies abroad, the birth costs of the general hospital ward up to twice the tariff of the canton of residence (according to EU provisions of the bilateral contracts)
- One examination each by a doctor and a midwife until the 10th week after birth
- Nursing and initial examination costs of the new-born
- Three breastfeeding consultations with midwives or recognized nurses
- A hand-operated breast pump (the electric one is only taken over with a doctor's prescription)

Important: A normal birth (without complications) is exempt from the deductible and the retention fee, but there are exceptions (premature births, complications, etc.). For examinations and controls that exceed the specified KVG services, the deductible and retention fee are charged.

Supplementary insurance

With supplementary insurance you can have the following extra benefits:

- breastfeeding allowance of approximately 200 CHF
- Pregnancy gymnastics, gymnastics and yoga
- Birth preparation courses
- Post-gymnastics exercises
- Alternative and natural healing methods for therapists
- Birth in the semi-private or private hospital ward in or outside the canton of residence

Cancellation of health insurance

If you are unsatisfied with your current insurance company, because of the premium, customer service or handling settlements you may choose another one.

Regarding compulsory health insurance, you need to have it if you live or work in Switzerland. Therefore, it is only possible to switch the insurance company but never to cancel it completely. There are two dates for when you can cancel basic insurance. If you have a standard model (free choice of doctor) and a deduction of 300 CHF, you may cancel your agreement by 30th of June with a cancellation period of one month. In any other case (different type or different deduction) you can only cancel your agreement by the end of the year (31st of December), also with a cancellation period of one month.

On the other hand, supplementary insurance follows different rules. You only have one cancellation date, which is on the 31st of December. Most insurance companies have a cancellation period of three months. Some companies have even six months. If you skip the cancellation date, your contract automatically extends by one year.
If you have a multiple-year contract, it is not possible to cancel the agreement earlier than the agreed period. The only exception to this rule is if the premiums change.

General notes

Relocation is not a reason to cancel an insurance agreement. If the premium gets higher through your relocation, you are obliged to pay the higher premium.

The cancellation letter must arrive at the insurer before the cancellation date is over. It is recommended to send letters by registered mail.

Bear in mind, since supplementary insurance is voluntary insurance and the insurer can decide whom they wish to accept for this insurance, you should never cancel supplementary insurance without first obtaining detailed information about the conditions under which a new company would offer supplementary insurance. Only when you have signed a contract with a new insurance company and have confirmation of acceptance, should you cancel an old agreement (to avoid unnecessary risk).

We handle all the cancellation procedures for our clients, considering all matters such as due dates, coverage, etc. — a complete carefree package.

Premium reduction

The insurance companies collect the premium without taking into account the insured person's income or assets. This can lead to a large financial burden. Premium reduction is intended to reduce the burden on people living in economically modest circumstances, which is caused by the premium of compulsory health care insurance. Premium reduction applies only to basic insurance and not to supplementary insurance. However, this is a cost which you can easily optimize with our personalized comparison.

Depending on the canton you live in, you may have to apply for the premium reduction yourself. Certain cantons check annually based on your tax return whether you are entitled to the premium reduction. You will then be informed automatically by your canton of residence.

Most health insurance companies process the cantons' electronic reports daily. Most premium reduction is taken into account in the next settlement. Most cantons do not inform health insurers and the beneficiary at the same time. This can mean that you have received the notification of entitlement to the premium reduction in writing, but the premium reduction has not yet been taken into account by health insurance company.

Our advice: If you wish to avoid late payment, pay the health insurance premium bill. If this is not possible, contact your health insurance company and let them know that you have been entitled to premium reduction. Request a deferment until the premium reduction is paid out. Most health insurers do this with one call.

Recommendations, frauds and discounts

Recommendations

Choose one of the insurance types to have lower premiums. You might save 10% to 20% in comparison to the standard model.

If you do not follow the rules of the insurance type, you are put into the standard model by the insurance company.

Choose the appropriate deduction for yourself. If you rarely go to a physician, it is recommended to choose a high deduction to safe most in premium (approximately 1'440 CHF). But bear in mind, in case of a serious illness, you would also need to pay the deduction and the retention fee (in the worst case 2'500 CHF + 700 CHF).

In case you are working more than 8 hours per week, you may exclude the accidental coverage from your health insurance policy, because your employer is obliged to insure you against accidents happening during work and in leisure time.
For the supplementary insurance, on the other hand, it is not recommended excluding the accidental insurance, because the coverage is usually higher than the coverage of the employer. Detailed information can only provide your employer.

Choose always supplementary insurance too. A small package starts from a little monthly premium and increases your benefits massively. It is always worth the money.

In case of a solution with supplementary insurance, compare multiple solutions of different insurance companies. The benefits and coverages can be very different. For basic insurance, every insurer offers the same coverage. The only difference for compulsory insurance is the price and customer service.

Keep the compulsory and the supplementary insurance at the same company. For the reimbursements and paying premiums, it is much more convenient to have all at one company. If you separate those two kinds of insurances, you might save a few Swiss Francs but you get some other trouble by the handling.

So far there are no online services which can provide you compulsory and supplementary as a whole package with a clear picture of what benefit you have for what premium. We recommend checking the premiums on the website of the Federal Office of Public Health for compulsory health insurance. Only they show you an independent and neutral picture. To clarify if your doctor fits the cheapest insurance model you may ask the corresponding insurance company or get a consultation by a broker.

Our company, insure me Ltd., is co-working with most insurance companies in the market. Therefore, we can offer a neutral and objective overview. We create transparent comparisons where you not only see prices but also what coverage you get for this price.

Discounts

Discounts on compulsory insurance are not allowed by law. If someone offers any discount, it is always related to supplementary insurance.

Many insurance companies offer discounts for couples and families. Those can be from 25% up to 100% for certain products of the supplementary insurance. Usually, the discount is related to the insurance for children and a condition is, that at least one parent is switching together with the child to the insurance company.

Some companies offer also other discounts such as starting discount, where the first few months or even the first year is discounted. Other offers are nappies for half a year or shopping coupons.

Fraud

Unfortunately, the insurance sector has a not so clean reputation. Among other things, this relates to unprofessional consultants who do not disclose the truth. Too often, these consultant are fully engaged in the process of signing a contract, but disappear after the deal is closed.

Furthermore, fraudulent call centres exist that call random telephone numbers. They pretend to work for an insurance company or even for the government. Please take note that a legitimate insurance company which you have never contacted would not randomly dial your number, just as the government would also not.

Often call centres report special discounts, refunds or low premiums. Since they do not know your current insurance, they cannot know if you would be entitled to a lower premiums or refund for anything, in the first place. Their main goal is to set up an appointment with you and then sell this appointment to an insurance broker or consultant. This broker or consultant often does not even know how the appointment was created and what was previously discussed by phone.

Do not trust random phone calls or uncertified consultants. If you are in doubt, call the mentioned institution by yourself and ask if the information you received is true or not.

insure me Ltd.

We are an independent insurance and financial security consulting company from central Switzerland. We provide our services free of charge, no strings attached. As well as checking insurance comparison platforms, we research over 20 health insurance operators individually to find a plan which best suits your needs.

Are you insured optimally yet? Do you need help comparing offers? We offer straightforward help:

1. Contact us and explain your needs and wishes.
2. If you already have an insurance contract, show us your current situation by sending a picture or scan by e-mail or WhatsApp.
3. Within 48 hours you will receive a unique and personalized health insurance comparison.
4. If you have questions, we will discuss them over the phone. If you are interested in any of our offers, we will realize them swiftly.

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