

## Entry notification from the employer

(Details of the employee to be insured)

Company

Mr	Ms
Surname	First name
Street	
Postcode/City/Country	
Date of birth	SI number 756.

Civil status	single	married	divorced
	registered partnership	dissolved partnership	widowed
Support obligation	yes	no	

Group/Plan	Company entry date
Employment level (%)	Insurance commencement date

Entry up to 15th day of the month: First day of the month / Entry after the 16th day of the month: First day of the following month

OASI annual salary (monthly salary x 12 or x 13)	HR number
---	-----------

Does the person to be insured:

have a complementary or executive pension? yes    no  
 ➔ If yes: which?

have an occupational pension with an external institution? yes    no  
 ➔ If yes: which?

Does the person to be insured have full capacity to work at the time the insurance is to commence?	yes	no
--	-----	----

They are not considered to have full capacity to work if, at the insurance commencement date, they

- are unable to attend work either fully or partially due to health reasons,
- are drawing daily allowances due to illness or an accident or have already registered a claim with an insurer,
- are drawing a full disability pension,
- can no longer attend their training to the level required due to health reasons.

Place, date

Employer's stamp and signature

## Entry notification from the employee

### 1. Insured person

Company \_\_\_\_\_

Surname \_\_\_\_\_

First name \_\_\_\_\_

Street \_\_\_\_\_

Postcode/City/Country \_\_\_\_\_

Date of birth \_\_\_\_\_

SI number 756.

Nationality \_\_\_\_\_

Tel. no. \_\_\_\_\_

E-mail \_\_\_\_\_

Correspondence

German

French

Italian

English

Civil status

single

married

divorced

registered partnership

dissolved partnership

widowed

Date of marriage/registered partnership \_\_\_\_\_

Surname, first name, date of birth of spouse/partner \_\_\_\_\_

Company entry date \_\_\_\_\_

Employment level (%) \_\_\_\_\_

**All available exit benefits from previous pension schemes must be transferred to us (Art. 60a OPO 2).**

- ➔ **We will send you the details for this transfer once we have received your entry conformation and pension certificate.**

### 2. Details required

Have you previously made an early withdrawal to purchase property (WEF)?

yes

no

Is your vested benefit pledged?

yes

no

Did you have full capacity to work at the time your insurance commenced?

yes

no

- ➔ **If no: you must complete the enclosed health questionnaire.**

Surname	First name
SI number	756.

Are you receiving benefits from disability insurance, military insurance, accident insurance or another occupational pension scheme? yes      no

➔ If yes: which? Degree of DI      %

Are you receiving benefits from a foreign disability or incapacity pension insurance scheme? yes      no

➔ If yes: which? Degree of DI      %  
Please provide the full address(es), including telephone number

➔ Please send the completed entry notification directly to us within 14 days. You can find our address in the letterhead.

---

Place, date Employee's signature

## Health questionnaire

Surname/First name

SI number 756.

Since when has your capacity to work been restricted?

Were you being monitored or treated by a doctor at the time your insurance commenced?

yes no

➔ If yes: for what reason?

➔ Since when?

➔ Doctor providing treatment\*?

Are you taking medication or have you been prescribed medication in the last five years?

yes no

➔ If yes: which? from when until when?

➔ For what reason?

➔ Doctor providing treatment\*?

In the past five years, have you been unable to work, partially or fully, for a period of more than two weeks as a result of illness, an accident or surgery?

yes no

➔ If yes: please provide details of the illness, injury or surgery.

resolved / not resolved

➔ From when and until when did the treatment take place?

➔ Are you intending/have you been recommended to have surgery (in- or outpatient)?

yes no

➔ Doctor providing treatment\*?

Were you subject to a reservation or premium supplement with your previous employer's occupational pension scheme due to health reasons?

yes no

➔ If yes: for what reason?

➔ Since when?

➔ Occupational pension scheme:

\*Please provide the full name and address.

A breach of the duty of notification entitles us to withdraw from the contract pursuant to Art. 6 of the Swiss Federal Act on Insurance Policies of 2 April 1908. We reserve the right to assess acceptance for the contractual insurance benefits on the basis of a medical examination report.

I hereby confirm that I have answered all questions truthfully and in full. I authorise the persons, institutions and insurance companies requested by the occupational pension scheme named above to provide all information required to verify my risk and benefit entitlement. I authorise the occupational pension scheme named above to pass on all data required for the purposes of providing insurance to the co-insurers, reinsurers and occupational pension schemes to which I belong or have belonged.

➔ Existing decisions/authorisations must be sent to us.

Place, date

Employee's signature