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VALITAS COMPACTA

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 | AHV/AVS number

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

01.2026

Entry notification from the employee

1. Insured person

Company

Surname | First name

Street

Postcode/City/Country

Date of birth | AHV/AVS number

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.**

01.2026

Surname	First name
AHV/AVS number	

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

01.2026

Health questionnaire

Surname/First name	AHV/AVS number

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 because 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 based on 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

01.2026