Erase data

VALITAS INDEPENDA

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

Is/Was there restricted work ability upon entry into the pension fund? ☐ yes ☐ no

➔ **If yes: you must complete the enclosed health questionnaire.**

Have you been absent from work for health reasons for more than 4 weeks in total or partially in the last 24 months? ☐ yes ☐ no

➔ **If yes: 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 scheme(s)? Degree of DI %

➔ **Existing decisions/authorisations must be sent to us.**

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

You do not need to inform us about the following: Tonsilitis, appendicitis, flu, colds, mumps, measles, rubella, chickenpox, contraceptives, childbirth and gynaecological examinations whose results were in the normal range.

Surname/First name AHV/AVS number

Height cm Weight kg

Do you regularly take medication? ☐ yes ☐ no

➔ If yes: for what reason?

➔ Since when?

➔ Doctor providing treatment (exact address)?

Have you received or are you currently receiving treatment for alcohol or drug abuse, or have you ever been advised to undergo treatment of this nature? ☐ yes ☐ no

➔ If yes: when?

➔ For how long?

➔ Treatment method?

Are you currently experiencing physical or psychological/mental illness, disorders or problems, or have you experienced them in the last five years? Are you experiencing the long-term effects of an accident or illness? ☐ yes ☐ no

Type of illness/accident, affliction, treatment, examinations	from	to	Duration of incapacity for work	Doctor, hospital or specialist (exact address and department)	Recovered without complications?

Duty of Notification and Data Protection Declaration
Insurers may require you to complete a risk assessment before accepting you into a scheduled insurance scheme.
Valitas Collective Foundation LPP (hereafter "Valitas") must transfer these risk assessments to any other reinsurers and to medical examiners for processing. As part of this process, Valitas and other reinsurers, as well as medical examiners, require full rights to check the information that you provide in the health questionnaire and to obtain further health-related information about you. Valitas and other reinsurers, as well as medical examiners, will process information about the state of your health for risk assessment purposes and to justify any reservations of rights.
I hereby declare that I have answered all of the questions on this form truthfully and in full. I acknowledge that any breach of my duty of notification may result in my benefits being reduced or refused and in claims for compensation being asserted against me. I consent to my health data being transferred to Valitas and any other reinsurers as well as to medical examiners and agree that they may use that data for the purposes set forth in this document. Valitas may obtain relevant information regarding my claim's history from my previous insurer or third parties, in particular authorities, medical practitioners and their auxiliary staff, as well as social insurance and occupational pension schemes to which I am or was affiliated, for the purposes of risk evaluation and claims management. I also consent to the obtaining of particularly sensitive personal data (e.g. health data) and personality profiles or the accessing and inspection of files maintained by public authorities where this is necessary for risk assessment purposes and for assessing my entitlement to benefits. To this end, I expressly release these medical practitioners and their auxiliary staff from their duty of confidentiality.

Place, date Employee's signature