

JOINING NOTICE

Company: _____ Connection No: _____

1. Personal Details

Last Name: _____ First Name: _____
 Street, No: _____ Postcode, City: _____
 Date of Birth: _____ Civil Status: single married
 divorced widowed
 registered partnership
 Ins. Number: _____ Gender: Man Woman
 Tel. P: _____ Tel. M: _____ E-mail P: _____

2. Joining Dates / Salary Details / Type of Employment

Joined the company: _____ Commencement of Insurance: _____
 AHV Salary: _____ Activity level in %: _____
 (calculated based on the full calendar year)
 Is the employment based on retraining by the Federal Disability Insurance (IV)? Yes No

3. Ability to work

Is the person to be insured currently and at the start of the insurance fully able to work? Yes No
 If not, please state degree of work incapacity: _____ Since when: _____
 Has the person to be insured submitted a benefits application to a social insurance scheme (IV, UV, MV) or to another type of insurance provider? Yes No
 If yes, which one: _____
 (If decision letter available, please enclose)
 Has a disability pension been reduced or cancelled due to IV Revision 6a? Yes No

4. Health Declaration

Did the previous employee benefits institution have a reservation or an additional premium for health reasons? Yes No
 If yes, since when: _____ Reason: _____
 Previous pension fund incl. address: _____

5. Further Information

Have entitlements to pension benefits or the entitlement to vested benefits been pledged or withdrawn in advance in the past? Yes No
 If yes, please indicate which one?: Pledged Withdrawn in advance
 Pledgee incl. address: _____

6. Comments

7. Declaration on Duty of Disclosure and Data Protection

We (company and insured person) hereby declare that we have answered all the questions on this form truthfully and completely. We are aware that any breach of the duty of disclosure may result in benefits being reduced or denied and that claims for damages may be brought.

The insured person authorizes the reinsurance company to process the data required to verify the risk and entitlement to benefits as well as to process the contract. If necessary, the data may be passed on, in particular to co-insurers and reinsurers, as well as to pension schemes of which the insured person is or has been a member.

Place and Date:

Signature of Person to be Insured:

Signature of Company
