Registration *(to be completed by the employer)*

Please complete in capital letter. Forms completed in full save you and us extra work. Thank you for your cooperation.

1. Company .... **Category** .... Contract No. ....

2. Particulars of person to be insured

First Name: ….. Last name: ....

Date of birth: .... AHV / AVS No.: ....

Sex: ☐ male ☐ female Function: ....

Civil status: ☐ single ☐ married ☐ in registered partnership ☐ divorced ☐ widowed

since: ....

Street: ..………... Postal code / place: ....

Language: ☐ German ☐ French ☐ English

Email: ..……….. Phone: ....

3. Beginning of pension as at: ....

4. Annual salary CHF: .... **Activity rate:** ....

(Annual salary details can be found in the pension rules or pension plan)

5. The employer confirms that the person to be insured is currently or was at the beginning of the pension relationship fully able to work:

☐ yes ☐ no,further details: ....

(Please enclose copies of the daily allowance statements)

....

Place and date **Stamp and signature of company**

05/2021

Für den internen Gebrauch:

Selbständig erwerbend:…………..………… Depot-Nr.………………………………………….. Satz B & St:……………………….

PensFlex Collective Foundation
Kauffmannweg 16 CH-6003 Lucerne
Phone +41 41 226 15 15 Fax +41 41 226 15 10
www.pensflex.ch info@pensflex.ch

PensFlex
Maximum individualization in occupational benefits

Personal questionnaire *(to be completed by the employee)*

First name, last name: .... **Company:** ....

6. **Height:** ……………………. cm **Weight:** ……………………. kg

7. **Is there a medical reservation in respect of the previous pension plan?**

☐ no ☐ yes, further details: ....
(please attach copy)

8. **Have benefits from your pension, disability, military or accident insurances been paid to you or are pending?**

☐ no ☐ yes, further details: ....
(please enclose copy of decision for annuities or daily allowance)

9. **Are you currently receiving medical treatment?**

☐ no ☐ yes, why?: ………..

Name and address of the treating doctor or hospital: ……………………………………………………………………………

……...

10. **Do you regularly take medicine, resp. has medicine been prescribed for you?**
(minimum one time per week)

☐ no ☐ yes, why and which ones: ……………………………………………………………………………………………

11. **Have you taken AIDS test that has produced an HIV-positive result or that is open to question?**

☐ no ☐ yes, when: ..………………..

12. **Have you seen, in the last 5 years, a doctor, a psychologist, a chiropractor or any other therapist following an accident, or an illness or has consultation /exam/treatment been recommended to you?**

☐ no ☐ yes, please give further details:

Type of illness/type of accident;infirmity;treatment;exam	from	to	Duration of the work incapacity	Doctor or hospital, complete address and department

13. **At your previous employer, was there a separate pension plan for extra-mandatory pension provision?**

☐ no ☐ yes Name of pension plan: ....

14. **Are you or were you once self-employed, paying contributions into „Large Pillar 3a“ (Large Pillar 3a only possible If you are not simultaneously a member of any occupational pension)?**

☐ no ☐ yes Name of Pillar 3a foundation: ....

15. **Did you arrive in Switzerland after the 01.01.2006?**

☐ no ☐ yes If yes, since when do you live in Switzerland? ……………………………………………..……………………

Since when have you first been affiliated to a swiss pension institution? ....

Conditions of admission for group insurances
The foundation and reinsurer decide on admission to insurance on the basis of health questions. Moreover, they can arrange a medical examination

Authorization
I hereby declare that I have answered all the questions in this form truthfully and in full, I am aware that any breach of the duty of disclosure may result in the reduction or refusal of benefits and in a claim for damages. I authorize the foundation and its reinsurer to process the data needed to verify the risk, the entitlement to benefits and the formation of the contract. If necessary, data may be forwarded, particularly to pension plans to which the insured belongs or has belonged. I authorize the foundation and its reinsurer to obtain information from members of the medical profession and their auxiliary persons, authorities, social security bodies and third parties, particularly in respect of the previous pension plan on any payments made. For this purpose I expressly absolve the members of the medical professional and their auxiliary persons from their duty to observe secrecy.

....
Place and date **Signature of person to be insured**