Admission notice for loss of earnings insurance due to illness

Insurer

☐ Groupe Mutuel Assurances SA ☐ Groupe Mutuel Assurances GMA SA
☐ Mutuel Assurances Maladie SA ☐ EasySana Assurance Maladie SA
☐ Philos Assurance Maladie SA ☐ Avenir Assurance Maladie SA

Employer

Company name _____ Contract No. _____
Postcode/Town _____ Category (if relevant) _____

Person to be insured

Name _____ First name _____
Date of birth _____ Gender _____
Insurance No _____ Occupation _____
Marital status _____ Date of marriage _____
Nationality _____ Residence permit _____

Language: ☐ F ☐ D ☐ I ☐ E

Full address :

_____

Date of admission _____ Annual AVS/AHV salary (CHF) _____ Activity rate (%) _____

For self-employed persons within the meaning of the AVS/AHV, insured annual income : CHF _____

Additional questions

Does the person to be insured have full capacity for work? ☐ yes ☐ no

Does the person to be insured receive daily allowance benefits or pensions from the disability insurance (AI/IV), accident insurance (LAA/UVG), from the health insurer or from other insurers? ☐ yes ☐ no

If yes, from? _____ Degree of disability (%) _____

Please enclose a copy of the decision

Date and place :	Signature and stamp of the employer :

The enclosed medical questionnaire must be completed by the person to be insured.

Medical questionnaire - Confidential

Insurer

☐ Groupe Mutuel Assurances SA ☐ Groupe Mutuel Assurances GMA SA
☐ Mutuel Assurances Maladie SA ☐ EasySana Assurance Maladie SA
☐ Philos Assurance Maladie SA ☐ Avenir Assurance Maladie SA

Name _____ First name _____

Date of birth _____ Employer _____

Name, first name and address of the family doctor or attending doctor:

_____

1. Are you currently undergoing medical treatment, or have you undergone medical treatment in the last five years?	☐ no	☐ yes
2. Have you ever been hospitalized or is hospital treatment planned?	☐ no	☐ yes
3. Are you currently or have you ever been declared incapacitated for work?	☐ no	☐ yes
4. Are you currently on medication?	☐ no	☐ yes
5. Have you ever had an accident the sequels of which render future treatment likely?	☐ no	☐ yes
6. Have you ever had psychotherapy?	☐ no	☐ yes
7. Are you currently suffering from or have you ever suffered from substance addiction (drugs, medicine or alcohol)?	☐ no	☐ yes
8. Have you ever tested positive for Aids?	☐ no	☐ yes

If yes, result: ☐ Aids positive ☐ Aids negative

Do you currently suffer or have you suffered from any health problems or do you have any dispositions for the following diseases:

9. of the respiratory organs (e.g. asthma, chronic bronchitis, emphysema, pneumonia)?	☐ no	☐ yes
10. of the cardiovascular system (e.g. heart problems, blood pressure, embolisms, varicose veins, thrombosis)?	☐ no	☐ yes
11. of the digestive tract (e.g. the oesophagus, stomach, gall bladder, liver, pancreas, intestines, haemorrhoids)?	☐ no	☐ yes
12. of the bones, joints or muscles (e.g. rheumatism, osteoarthritis, osteoporosis, malformations)?	☐ no	☐ yes
13. of the back (e.g. herniated disk, cervical problems, sciatica, lumbago)?	☐ no	☐ yes
14. of the eyes or ears?	☐ no	☐ yes
15. of the kidneys, genitalia, bladder or prostate (e.g. kidney stones, malformations, tumours)?	☐ no	☐ yes
16. of the nervous system (e.g. symptoms of paralysis, epilepsy, migraines, dizziness, tumours)?	☐ no	☐ yes
17. of the metabolism or blood (e.g. diabetes, gout, anaemia, leukaemia, spleen disorders)?	☐ no	☐ yes
18. of the endocrine system (e.g. thyroid, adrenal disorders, pituitary gland)?	☐ no	☐ yes
19. of the skin (e.g. allergies, eczema, psoriasis, cancers)?	☐ no	☐ yes
20. other conditions, malformations or disabilities not mentioned above?	☐ no	☐ yes

For women

21. Have you suffered or do you suffer from a gynaecological condition, a breast condition, sterility? ☐ no ☐ yes

22. Are you pregnant? If yes, expected date of delivery? _____ ☐ no ☐ yes

23. Indicate your height and weight? Height _____cm Weight _____ kg

24. Do you smoke? If yes, how many per day? _____ ☐ no ☐ yes

25. Has a previous coverage, LPP/BVG benefit or disease, been subject to a reservation, refused or limited to certain specified benefits? ☐ no ☐ yes

If yes, reason and name of the insurer concerned _____

26. Have you already exhausted your right to loss of earnings insurance with an insurer? ☐ no ☐ yes

If yes, which one and when?_____

If you have answered "yes" to any of questions 1 to 20, please complete the following table:

point No	type of illness or accident (diagnosis, medication)	year	duration of treatment	operated	incapacity for work	recovered without consequences	attending doctor/hospital/ address
				■ no ■ yes	☐ no ☐ yes Duration :	☐ no ☐ yes	
				☐ no ☐ yes	☐ no ☐ yes Duration :	☐ no ☐ yes	
				☐ no ☐ yes	☐ no ☐ yes Duration	☐ no ☐ yes	
				☐ no ☐ yes	☐ no ☐ yes Duration	☐ no ☐ yes	

Statement of the person to be insured

I declare by my signature that I have answered the above questions completely and truthfully and that the written answers by a third party are in accordance with my instructions. For all questions related to this questionnaire, I release doctors, paramedical staff, hospitals, previous insurers and other insurers from their obligation to keep any information confidential from the insurer. I authorise the insurer to process the necessary data. In the event of false or incomplete declarations, benefits will be refused by the insurer. The LPP/BVG pension fund reserves the right to review the admission based on the information obtained. For reasons of administrative simplification, if my employer is affiliated to Groupe Mutuel for loss of earnings benefits due to illness and for LPP/BVG benefits, this statement will be sent to the insurer for loss of earnings benefits and to the LPP/BVG pension fund.

Comments: _____

Date and place :

Signature of the person to be insured :