Admission notice for loss of earnings insurance due to illness

Insurer

☐ Mutuel Assurances SA ☐ Groupe Mutuel Assurances GMA SA
☐ Mutuel Assurance 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, place, signature and stamp of the employer

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

Groupe Mutuel
Rue des Cèdres 5 – P.O. Box - CH-1919 Martigny

Medical questionnaire - Confidential

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Name: _____ First name: _____

Date of birth:_____ Employer: _____

Name, first name and address of family doctor or general practitioner:

_____

1. Have you followed any medical treatment in the last 5 years or are you currently following any medical treatment? ☐ no ☐ yes
2. Have you been hospitalised or is hospitalization currently being considered? ☐ no ☐ yes
3. Have you been or are you currently unable to work? ☐ no ☐ yes
4. Are you currently taking any medication? ☐ no ☐ yes
5. Have you suffered any accidents, the consequences of which are likely to lead to future treatment? ☐ no ☐ yes
6. Have you been undergoing psychotherapy? ☐ no ☐ yes
7. Do you suffer or have you suffered from any addiction diseases (drugs, medication, alcohol)? ☐ no ☐ yes
8. Have you been tested for HIV (AIDS)? ☐ no ☐ yes

   If yes, what was the result? ☐ HIV positive ☐ HIV negative

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

9. respiratory organs (e.g. asthma, chronic bronchitis, emphysema, pneumonia)? ☐ no ☐ yes
10. the cardiovascular system (e.g. heart problems, blood pressure, embolism, varicose veins, thrombosis)? ☐ no ☐ yes
11. disorders of the digestive system (e.g. oesophagus, stomach, gallbladder, liver, pancreas, intestines, haemorrhoids)? ☐ no ☐ yes
12. bones, joints or muscles (e. g. rheumatism, osteoarthritis, osteoporosis, malformations)? ☐ no ☐ yes
13. back (e.g. herniated disc, cervical damage, sciatica, low back pain)? ☐ no ☐ yes
14. eyes or ears? ☐ no ☐ yes
15. kidneys, genital organs, bladder or prostate (e.g. stones, malformations, tumours)? ☐ no ☐ yes
16. the nervous system (e.g. symptoms of paralysis, epilepsy, migraines, dizziness, tumours)? ☐ no ☐ yes
17. metabolism, blood (e.g. diabetes, gout, anaemia, leukaemia, spleen disease)? ☐ no ☐ yes
18. endocrine diseases (e.g. thyroid, adrenals, pituitary gland)? ☐ no ☐ yes
19. skin (e.g. allergies, eczema, psoriasis, cancers)? ☐ no ☐ yes
20. other conditions, deformities 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

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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:

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_____

Date, place, signature of the person to be insured