

Affiliation notification

Employer

Company Contract N°

Plan

Base plan Executive/complementary plan Other

Person details of insured

Last name

First name

AVS N° . . . Date of birth / /

E-mail Telephone

Address

Occupation

Civil status single married divorced widow(er)

registered partnership dissolved partnership

Gender male female Subscribe to newsletter yes no

Partner

If married or bound by a registered partnership, date of marriage/partnership / /

First name of spouse/partner Date of birth / /

If divorced or partnership dissolved, date of divorce/dissolution / /

Children (if under 25 years of age)

First name Date of birth / /

/ /

/ /

/ /

Entry into insurance

Date of entry / /

Annual AVS salary (CHF) .

Employment rate (%) .

Note

If temporary or seasonal employment, please convert split salary to annual salary.

If AVS salary exceeds CHF 250'000.-, the insured person will receive a health declaration to be completed.

Affiliation notification

Details of former employer/former pension institution

Company name and address of former employer	Company name and address of the former pension fund	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Work capacity

Is the person to be insured in full working capacity? yes no

Does the person to be insured receive a pension from the federal disability insurance? yes no

If yes, degree of pension (%) .

Was the person to be insured subject to an impaired condition of affiliation with the former pension institution? yes no

Signature

Date	<input type="text"/> / <input type="text"/> / <input type="text"/>	Stamp, signature of employer
Place	<input type="text"/>	
<input type="text"/>	<input type="text"/>	