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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 D D / M M / Y Y Y Y

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 D D / M M / Y Y Y Y

First name of spouse/partner Date of birth D D / M M / Y Y Y Y

If divorced or partnership dissolved, date of divorce/dissolution D D / M M / Y Y Y Y

Children (if under 25 years of age)

First name	Date of birth
	D D / M M / Y Y Y Y
	D D / M M / Y Y Y Y
	D D / M M / Y Y Y Y

Entry into insurance

Date of entry D D / M M / Y Y Y Y

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.

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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

Y Y Y Y

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 / /

Place

Stamp, signature of employer