



**teIICO**

Pension solutions. Banking. Real estate.

**Tellico pkPRO**

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## Power of attorney for reinsurer

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The benefits test in the case of an incapacity for work is carried out by the Tellico pkPRO re-insurer, Schweizerische Mobiliar Lebensversicherungs-Gesellschaft AG. So that die Mobiliar can request the necessary documents directly, please return the signed power to the abovementioned address.

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### a) Other insurers

In view of the investigation of the claim and the examination of the entitlement to benefits of the insured person, the undersigned hereby expressly entitles die Mobiliar to procure the necessary information and in particular to examine the relevant files (e. g. medical report and reports from other institutions such as career counselling) from all the insurance carriers under public and private law such as health insurance schemes, medical insurance, daily benefits insurance, accident insurance, disability insurance, pension funds, 2nd Pillar Central Office & Liaison Office etc.

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### b) Doctors and other medical services providers

Die Mobiliar is also authorised by the undersigned to acquire all the information that it deems necessary from doctors and other medical services providers such as hospitals, nursing homes, etc. The doctors and the institutions named are therefore unconditionally released from their duty of confidentiality vis à vis die Mobiliar.

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### c) Forwarding of own files

Moreover, the undersigned hereby authorises die Mobiliar to forward documents detailing the course of the incapacity for work, in particular medical documents, to the relevant IV offices, in order to increase the possibility of reintegration into professional life thereby. However, this action does not replace the need to notify the IV, which the insured person must carry out himself/herself.

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### Insured person

|                             |                             |                 |                      |
|-----------------------------|-----------------------------|-----------------|----------------------|
| <input type="checkbox"/> Mr | <input type="checkbox"/> Ms |                 |                      |
| Surname                     | <input type="text"/>        | First name      | <input type="text"/> |
| Street                      | <input type="text"/>        | Postcode, place | <input type="text"/> |
| Insured no.                 | <input type="text"/>        | Date of birth   | <input type="text"/> |

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By signing below the signatory hereby grants the abovementioned power of attorney in full from a) to c).

Place, Date

Signature of the insured person or his/her legal representative