tellco
Pension solutions. Banking. Real estate.

Tellco pkFLEX
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Health declaration for group insurance

Employer **Contract no.**

Data of person to be insured

○ Mr ○ Ms

Surname First name

Street Postcode, Place

Date of birth Insured no.

Prof. activity/function

AHV/AVS salary (for a full calendar year) CHF Degree of employment (%)

Marital status ○ Single ○ Married ○ Widowed Date of marriage/registration of partnership

○ Separated ○ Divorced Date of divorce/dissolution of partnership

Support obligations ○ Yes ○ No Covered by UVG/LAA ○ Yes ○ No

Reason for application

Change ○ Admission to the employee benefits institution ○ Increase in benefits

○ Effective date

Only answer in case of new admission to the employee benefits institution:
Is the employment due to vocational retraining measures by the national disability insurance (IV/AI)? ○ Yes ○ No

Working capacity

Is the person to be insured fully capable of work at present and at commencement of the insurance? ○ Yes ○ No

If not, Degree of incapacity for work (%) Since when?

Has the person applied for benefits from a social security institution (IV/AI, UVG/LAA, MV/AM)
or any other insurance company? (If decision available, please enclose.) ○ Yes ○ No

If yes, at which one/s?

The person to be insured and the policyholder hereby confirm the correctness and completeness of the information provided.

Place, Date Signature of person to be insured

Please note: The reverse side must be completed and signed by the person to be insured.

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Health declaration

1. Height in cm _____ Weight in kg _____
2. Do you currently take or have you been prescribed any medication? ○ Yes ○ No
   If yes, from _____ to _____
   What kind and why? _____
   Physician (full address) _____
3. Do you take or have you ever taken any narcotics (drugs) or other addictive substances? ○ Yes ○ No
   If yes, from _____ to _____ what kind? _____
4. Have you taken an AIDS test which showed a positive or potentially positive result? ○ Yes ○ No
   If yes, when? _____
5. Do you suffer or have you, in the past 5 years, suffered from any physical, psychological or mental illness, impairment or disorder? Do you suffer from the consequences of an accident, an illness or an infirmity? ○ Yes ○ No
   If yes, what kind? _____

Type of illness/accident/infirmity, treatment, examinations	From	To	Duration of incapacity for work	Treating physician or hospital (incl. full address and hospital department)

The re-insurer reserves the right to examine a relevant medical report prior to admitting the person to be insured to the contractual insurance benefits.

Previous employee benefits coverage (to be filled in only in case of new admission to the employee benefits institution)

Was there a proviso or a supplementary premium in force for health reasons at the previous employee benefits institution? ○ Yes ○ No

If yes, since when? _____ Reason _____

Previous employee benefits institution (incl. address) _____

Please enclose the certificate of the previous employee benefits institution showing the death and disability benefits insured.

Have any claims to employee benefits or to vested benefits ever been pledged? ○ Yes ○ No

If yes, to whom? _____

Has any full or partial advance withdrawal of vested benefits been made? ○ Yes ○ No

If yes, when? _____ CHF _____

Declaration regarding the obligation of disclosure and data protection

I hereby declare to have answered all the questions on this form truthfully and completely. I am aware that any violation of the duty of disclosure can result in a reduction or refusal of benefits and that damages may be claimed. By signing this application form, I authorise the re-insurer to process the data necessary for the examination of the application, the processing of the group insurance and the assessment of any claim to benefits (e.g. name, date of birth, etc.). The re-insurer is authorised to obtain relevant information, especially with regard to risk assessment and the handling of claims to benefits, about my former claims experience from previous insurer(s) or from third parties, in particular from medical practitioners and their auxiliary staff, authorities and social security institutions. If necessary for the purpose of assessing risk and/or the entitlement to benefits, this authorisation also extends to the procurement of particularly confidential personal data (such as health-related data) and personality profiles and/or the right to inspect official documents. For this purpose, I explicitly release medical practitioners and their auxiliary staff from the obligation of maintaining professional secrecy. If necessary for the processing of the group insurance or the handling of claims to benefits, I authorise the re-insurer to transmit personal data for processing to third parties in Switzerland and abroad who are involved in the contract, in particular to co-insurers and reinsurers, as well as to employee benefits institutions to whom I am or was affiliated and to the re-insurer companies involved in the processing of the insurance.

Place, Date _____ Signature of person to be insured _____