PensFlex

Registration *(to be completed by the employer – please complete in block capitals)*

1. Contract details:

Employer: ..... Contract no.: .....

Category: .....

2. Personal details of person to be insured:

Surname: ..... First name: .....

Street, no.: ..... Postcode / town: .....

Date of birth: ..... AHV / OASI No.: .....

Private email: ..... Phone / mobile (private): .....

Civil status: ☐ single ☐ married* ☐ in registered partnership* ☐ divorced* ☐ widowed*

*__Date__ of marriage / registered partnership / divorce / widowhood**:** .....

Sex: ☐ male ☐ female

Language: ☐ German ☐ French ☐ English

3. Pension relationship:

Start date: .....

Annual salary CHF: ..... activity rate in %: .....

Detailed information on the annual salary can be found in the pension fund regulations or pension plan.

4. The employer confirms that the person to be insured is or was fully able to work on the date of registration:

☐ yes

☐ no if no, degree of disability: .....% incapacitated to work since: .....

5. Remarks:

.....

.....

6. Signature:

By signing this document, the employer confirms that the information given is complete and correct.

....

Place, date **Stamp, signature of the employer**

03/2024

PensFlex Collective Foundation
Kauffmannweg 17 6003 Lucerne
T +41 41 226 15 15 welcome@pensflex.ch
www.pensflex.ch

PensFlex

Personal questionnaire *(to be completed by the employee)*

First name, last name: ..... **Employer:** .....

1. Height: ..... cm **Weight:** ..... kg

2. Are you partially or fully unable to work both currently and when insurance cover begins? ☐ no ☐ yes

.....

If yes, degree of incapacity for work in % *from* *to*

3. Have you applied for benefits from a social security institution (IV/AI, UVG/LAA, MV/AM) or any other insurance company? ☐ no ☐ yes

.....

If yes, at which one(s)?

4. Do you currently take, or have you been prescribed any medication? ☐ no ☐ yes

.....

If yes, which medication *Reason for the medication* *from* *to*

.....

Physician (name and full address)

5. Have you ever or are you currently undergoing treatment for alcohol or drug abuse, or have you been advised to do so? ☐ no ☐ yes

.....

If yes, what kind? *from* *to*

6. Was there a restriction or a supplementary premium in force for health reasons at the previous occupational benefits institution? ☐ no ☐ yes

.....

If yes, since when and why (deliver copies) *Previous employee benefits institution (incl. address)*

7. Do you suffer or have you, in the past 5 years, suffered from any physical, psychological or mental illness, impairment or disorder? If yes, what kind? Do you suffer from the consequences of an accident, an illness, or an infirmity? ☐ no ☐ yes

Type of illness / accident / infirmity, treatment, examinations	from	to	Duration of the work incapacity	Treating physician or hospital incl. full address and hospital department

8. At your previous employer, was there a separate pension plan for extra-mandatory pension provision? ☐ no ☐ yes

Name of pension plan: .....

9. Are you or were you once self-employed, paying contributions into „Large Pillar 3a“ (Large Pillar 3a is only possible If you are not simultaneously a member of any occupational pension)? ☐ no ☐ yes

Name of Pillar 3a foundation: .....

10. Did you arrive in Switzerland after the 01.01.2006? ☐ no ☐ yes

If yes, since when do you live in Switzerland? .....

Since when have you first been affiliated to a Swiss pension institution? .....

PensFlex Collective Foundation
Kauffmannweg 17 6003 Lucerne
T +41 41 226 15 15 welcome@pensflex.ch
www.pensflex.ch

Conditions of admission
The foundation and reinsurer decide on admission to insurance on the basis of health questions. Moreover, they can arrange a medical examination.

Authorization
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 compensatory damages may be claimed. I authorize the employee benefits institution respectively the reinsurer to process the data necessary for the risk examination, the fulfilment of the contract and the assessment of any claim to benefits. If necessary, the data may be passed on, in particular to employee benefit institutions to which the insured person belongs or has belonged. I authorize the employee benefits institution respectively the reinsurer 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, as well as any employee benefits institutions to whom I am or was affiliated. If necessary for the purpose of assessing risk and/or the entitlement to benefits, this authorization 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 the fulfilment of the group life insurance contract or the handling of claims to benefits require coordination with other employee-benefit-related contracts through which I am also insured with the same insurer as part of the occupational pension plan, I authorize the insurer to transmit personal data (including particularly confidential personal data such as health-related data) for processing to third parties in Switzerland and abroad who are involved in the group life insurance contract or any other employee-benefit-related contract through which in particular to coinsurers and reinsurers, as well as to employee benefits institutions to whom I am or was companies involved in the processing of the insurance.

I also agree fully that in order to ensure the quality of the advice, pension-related information (excluding any health-related questions) may be exchanged with the bank partner / asset manager or the broker / agent concerned.

....
Place, date **Signature of person to be insured**

03/2024

PensFlex Collective Foundation
Kauffmannweg 17 6003 Lucerne
T +41 41 226 15 15 welcome@pensflex.ch
www.pensflex.ch