Application / Health declaration for group life insurance

la Mobilière

Important notice: The official languages of «Swiss Mobiliar» are German and French. No rights for any further correspondence in English can be derived from this form for any party at any time.

Information on the policyholder

Name

Contract no.

Category

For collective benefits institutions: name of the affiliated employer

Data of person to be insured

Surname / First name

Street, no.

Postcode, town

Date of birth

AHV/AVS no.

Prof. activity / function

AHV/AVS salary (for a full calendar year) CHF

Degree of employment %

Sex ☐ Male ☐ Female

Marital status ☐ Single ☐ Widowed ☐ Married ☐ In registered partnership ☐ Divorced ☐ Partnership dissolved

Date of marriage / registration of partnership

Language[1)] ☐ German ☐ French ☐ Italian ☐ English

Support obligations ☐ Yes ☐ No

Covered by UVG/LAA ☐ Yes ☐ No

[1)] Defines the language of correspondence between the employee benefits institution and the person to be insured.

Date of divorce / dissolution of partnership

Reason for application

Change ☐ Admission to the employee benefits institution ☐ Increase in benefits ☐ Other

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 partially or fully unable to work both currently and when insurance cover begins? ☐ Yes ☐ No

If yes: 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)?

Has a disability pension been reduced or cancelled due to IV/AI revision 6a? ☐ Yes ☐ No

If yes: Degree of disability before reduction % End of 3-year deferment period

(Please enclose an IV/AI decision if available.)

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

Signature of policyholder

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

Surname / First name _____ Date of birth _____

Health declaration

Do not specify: tonsils, appendicitis, flu, colds, mumps, measles, rubella, chickenpox, contraceptives, childbirth and gynaecological checkups with standard results.

1. Height _____ cm Weight _____ kg

2. Do you currently take or have you been prescribed any medication? ☐ Yes ☐ No

   If yes, from (date) _____ to _____ What kind and why? _____

   Physician (full address) _____

3. Have you ever or are you currently undergoing treatment for alcohol or drug abuse, or have you been advised to do so? ☐ Yes ☐ No

   If yes, from (date) _____ to _____ What kind? _____

4. 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? ☐ Yes ☐ No

Type of illness / accident / infirmity, treatment, examinations	From	To	Duration of incapacity for work	Treating physician or hospital incl. full address and hospital department	Fully recovered? Yes / No

Employee benefits institution 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

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 compensatory damages may be claimed.
By signing this form, I authorise the employee benefits institution respectively Swiss Mobiliar Life Insurance Company Ltd, Nyon (referred to as «La Mobilière» below) to process the data necessary for the risk examination, the fulfilment of the group life insurance contract and the assessment of any claim to benefits (e.g. name, date of birth, etc.). La Mobilière 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, 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 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 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 insured at La Mobilière, I authorise La Mobilière 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 I am insured at La Mobilière, in particular to coinsurers and reinsurers, as well as to employee benefits institutions to whom I am or was affiliated and to La Mobilière Group companies involved in the processing of the insurance.

Place, date _____ Signature of person to be insured _____

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