Mobilière Suisse
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la Mobilière

Application/Health declaration for group life insurance

Important notice: The official languages of La Mobilière 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 _____
Street, no. _____
Postcode, town _____

Contract no. _____
Category _____

Data of person to be insured

Surname _____
Street, no. _____
Postcode, town _____
Date of birth _____
AHV/AVS no. _____
Prof. activity / function _____
AHV/AVS salary CHF _____
(for a full calendar year)
Degree of employment _____%

First name _____
Sex ☐ Male ☐ Female
Marital status ☐ Single ☐ Widowed
☐ Married ☐ In registered partnership
Date of marriage /
registration of partnership _____
☐ Divorced ☐ Partnership dissolved
Date of divorce /
dissolution of partnership _____

Language[1)] ☐ German ☐ French ☐ Italian ☐ English
Support obligations ☐ Yes ☐ No
Covered by UVG/LAA ☐ Yes ☐ No

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 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)? _____
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.

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

Health declaration

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. Do you take or have you ever taken any narcotics (drugs) or other addictive substances? ☐ Yes ☐ No
   If yes, from (date) _____ to _____ What kind? _____

4. Have you taken an AIDS test which showed a positive or potentially positive result? ☐ Yes ☐ No
   When? _____

5. 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)

La Mobilière 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 La Mobilière 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 co-insurers 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