

# Information regarding state of health

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Last name \_\_\_\_\_ First name \_\_\_\_\_

Company \_\_\_\_\_ Social insurance number 756. \_\_\_\_\_

During the last 5 years, did you have any health problems or complaints that resulted in a full or partial incapacity for work of more than 3 weeks, or do you have any health problems or complaints at the moment? ☐ Yes ☐ No

If yes, what? \_\_\_\_\_

Are you or have you been in the last 5 years under medical investigation, receiving medical treatment and/or checks by a doctor or another medical specialist (e.g. psychologist, psychotherapist, chiropractor, osteopath, physiotherapist, etc.)? ☐ Yes ☐ No

In the last 5 years have you been examined, treated or operated on in a hospital or another medically run institution? ☐ Yes ☐ No

### Details about the last two questions:

| For which illnesses or complaints, etc.? | From when to when? | Comments | Name and address of treating physicians, specialists and/or hospitals |
|------------------------------------------|--------------------|----------|-----------------------------------------------------------------------|
| _____                                    | _____              | _____    | _____                                                                 |
| _____                                    | _____              | _____    | _____                                                                 |
| _____                                    | _____              | _____    | _____                                                                 |
| _____                                    | _____              | _____    | _____                                                                 |

Do you take any medication on a regular basis (excluding contraceptive pills)? ☐ Yes ☐ No

If yes, which? \_\_\_\_\_ Doctor providing treatment \_\_\_\_\_

Exact address \_\_\_\_\_

Is there a health reservation from your previous pension fund? ☐ Yes ☐ No  
(If yes, please enclose a copy of the health reservation letter in a sealed envelope.)

Have you been in receipt of benefits in the last 5 years in accordance with the federal IV, MVG, UVG, BVG, a foreign social security insurance or another insurance, or have you applied for benefits?  
(Please enclose copies of the decisions of the named institutions.) ☐ Yes ☐ No

If yes, from which? \_\_\_\_\_ If yes, for which level of IV? \_\_\_\_\_

Duration of benefit receipt? From \_\_\_\_\_ to \_\_\_\_\_ Annual pension or daily benefits allowance \_\_\_\_\_

**Release from professional and/or official confidentiality/permission to inspect files**

The above questions must be answered truthfully. In the event of a violation of the obligation to notify or of incomplete information, Swisscanto Flex Collective Foundation and/or its reinsurer may reduce or refuse benefits in accordance with the statutory provisions. The person to be insured authorises the Swisscanto Flex Collective Foundation and its reinsurer to obtain reports from its company medical officers as required and to obtain directly all the information required to check the acceptance and benefit entitlement from all the doctors that have ever treated the person to be insured, from all the carriers with which the insured person was insured as well as from the relevant IV office and the compensation fund. The insured person hereby releases these persons/offices from their duty of professional secrecy and their obligation to maintain confidentiality. Only information that is strictly necessary will be collected and all the data will be handled with the utmost confidentiality by Swisscanto Flex Collective Foundation and its reinsurer. The relevant data will be used exclusively for the contractual processing of the occupational benefits insurance.

\_\_\_\_\_  
Place, date

\_\_\_\_\_  
Signature of the person to be insured

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