

# Affiliation notification



Company: ..... Contract n° : .....

Basic plan     Management plan/complementary     Other : .....

## Personal data of the insured

Name and first name: ..... Date of birth: .....

AVS N°: ..... Sex:     masculine     feminine

Profession: .....

Address: .....

Civil status:     bachelor                       married                       divorced                       widow(er)  
                     bound by a registered partnership                       dissolved partnership

If married or bound by a registered partnership, date of marriage/partnership: .....

First name of spouse/partner: ..... Date of birth: .....

If divorced or partnership dissolved, date of the divorce/dissolution of the partnership: .....

Children (if under 25 years of age):	First name	Date of birth
	.....	.....
	.....	.....
	.....	.....

## Entry into the insurance

Date of entry: .....

Annual AVS salary:    Fr. ....

Rate of activity: ..... %

Note: If the AVS salary exceeds Fr. 150'000.-, the insured will receive a declaration of health to be completed.

(If temporary or seasonal employment, convert fragmented salary into an annual one).

## Details of former employer/former pension fund

Corporate or business name of the former employer	Corporate or business name of the former pension fund	Year
.....	.....	.....
.....	.....	.....
.....	.....	.....

## Capacity to work

Does the person to be insured possess a full capacity to work?     yes     no

Is the person to be insured in receipt of a federal disability pension?     yes     no

If yes, degree of pension: ..... %

Was the person to be insured subject to an impaired condition of affiliation with the former pension institution?     yes     no

## Enclosure

If the declaration of health overleaf is completed, include the last insurance certificate from the former pension institution of the employee

Date: ..... Stamp, signature of employer: .....