

COPRE

NOTIFICATION OF ENTRY

Affiliated company: Contract No.:

Group of persons insured: Category:

Personal data of the insured person

Name and first name: Date of birth:

AVS No.: Gender: ☐ M ☐ F

Address: Language: ☐ French ☐ German

☐ English ☐ Italian

Tel. private/mobile: Mail:

Civil status from: ☐ single ☐ married ☐ divorced

☐ bound by a registered partnership ☐ partnership dissolved ☐ widow(er)

Date of entry:

Annual AVS salary: CHF Level of activity:%

(In case of part-time employment, please indicate the annualised salary corresponding to the actual rate of activity)

(If temporary or seasonal employment, convert the partial salary to an annual salary)

Remark: A medical examination is required when the insured person exceeds for the first time the limit of CHF 400'000.-, then at each salary increase which exceeds 20% or CHF 50'000. (We send the health questionnaire to the insured person)

Details of the employer/former pension fund

Corporate name and address of former employer

Corporate name and address of former pension fund

Ability to work

Is the person to be insured fully able to work? ☐ yes ☐ no

Does the person to be insured receive a federal disability insurance pension? ☐ yes ☐ no

If yes, degree of disability:%

Place and date: Stamp/Signature of employer: