Swisscanto
1e Collective
Foundation

Health declaration

Personal details of insured person

Surname _____ First name _____

Employer _____ Social insurance 756. _____

Health declaration

Do not specify the medical treatment or work incapacity related to an appendicitis, tonsils, dental care, contraception, childbirth.

1. Are you currently and at the beginning of the insurance cover not capable to work (fully or partially)? ☐ Yes ☐ No
   If yes, Degree of incapacity of work (%) _____ Since when? _____

2. Have you applied for benefits from a social security institution (IV/AI, UVG/LAA, MV/AM) ☐ Yes ☐ No
   or any other insurance company? (If decision available, please enclose.)
   If yes, at which one(s)? _____

3. Height _____ cm Weight _____ kg

4. 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) _____

5. Are you following or due to follow a treatment related to alcohol or drugs consumption, ☐ Yes ☐ No
   or have you been advised to do so?
   If yes, from (date) _____ to _____
   What kind? _____

6. Do you suffer or have you, in the past 5 years, suffered from any physical, ☐ Yes ☐ No
   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?
   If yes, what kind? _____

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

The foundation 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 (refered 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 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 _____

Swisscanto 1e Collective Foundation
P.O. Box
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