

Health declaration of the insured person – Pension Fund

Please complete the form in block capitals and sign it

Surname: _____ Name: _____
Street. _____ ZIP Code and City: _____
Social security no.: _____ Contract's starting date: _____
Date of birth: _____ Position : _____

Are you currently 100% healthy and without pain, and have you been in this situation in the last 12 months?

- yes
 no → In case of pain, which kind? _____

Do you have any chronic illness (such as diabetes, high blood pressure) or are you suffering from the effects of a previous illness or accident?

- no
 yes → If yes, which kind? _____

Do you have any birth disability?

- no
 yes → If yes, which kind? _____

Do you take medication regularly?

- no
 yes → If yes, which kind? _____

Do you currently receive a disability pension, an accident insurance pension or other pension benefits from a foreign country?

- yes → If yes which kind? _____
 no

Have you ever received a disability pension, an accident insurance pension or other pension benefits from a foreign country?

no

yes → from - to? _____

Is there a current pending pension request for a disability insurance, a health insurance or benefits in a foreign country?

yes

no

Have you suffered, in the last **10 years**, from a serious disease (e.g.: with hospitalization), had a serious accident or undergone a surgery?

no

yes → Details (Type of illness, accident, operation): _____

Name and address of the hospital / sanatorium / psychiatric facility:

Name of the doctor

Hospitalization's duration from _____ to _____

Name and address of the general physician:

Surname, Name

Street

ZIP code, city

In medical attention since

I hereby declare that all the information I have provided is complete and correct. The consequences of a misdeclaration are known to the undersigned. I authorize the Pension Fund to obtain additional information about my health conditions from responsible parties. These respondents are exempted from the duty of confidentiality towards the Pension Fund, but I request that they treat such information confidentially.

Place and date

Signature

This form must be fully completed, signed and returned to the Pensionskasse der Saurer-Unternehmungen..