Swisscanto
Collective Foundations of the Cantonal Banks

Delete entries

Swisscanto
Stiftungen/Fondations/Fondazioni

Supplementary Information for Risk Assessment (Medical questionnaire)

Contracting office:
Contract no.:
Policy no.:
Employer:
Street, no.:
Zipcode, city:

For the attention of the Helvetia Swiss Life Insurance Company Ltd (hereinafter Helvetia)

To be completed by the person to be insured or the insured person
Please fill in all fields and pages and sign

1 Personal details concerning the insured person

Last name: First name:

Profession: Description of employment:

Street, no.: Zipcode, city, canton:

Tel. no. (home): Tel. no. (work):

2 Information concerning the insured person

Date of birth: Commencement of service with the employer:

AHV insurance number: resident (Swiss):

Nationality (foreigners): , resident in Switzerland for years.

3 Proof of Health

3.1 Name, address and telephone no. of your general physician:

3.2 Have you been examined, treated or operated on during the past three years? ☐ Yes ☐ No

If yes, for what? a)
Duration (from - to) Consequences/results of the examinations Name and address of physician or hospital
-

If yes, for what? b)
Duration (from - to) Consequences/results of the examinations Name and address of physician or hospital
-

If yes, for what? c)
Duration (from - to) Consequences/results of the examinations Name and address of physician or hospital
-

If yes, for what? d)
Duration (from - to) Consequences/results of the examinations Name and address of physician or hospital
-

3.3 Are you currently suffering from health problems, afflictions or the consequences of an accident? ☐ Yes ☐ No

If yes, which? a)
since: Consequences or results of the examinations Name and address of physician or hospital

If yes, which? b)
since: Consequences or results of the examinations Name and address of physician or hospital

Delete entries

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3.4 Do you regularly take medication? ☐ Yes ☐ No

If yes, which (+ dosage)?

3.5 Are you restricted in terms of your capacity to work or earning ability? ☐ Yes ☐ No

If yes, from - to why? degree in %?

- %

- %

3.6 Height cm Weight kg

3.7 a) Have you had an AIDS test (HIV test)? ☐ Yes, when ☐ No

b) Which was the result? ☐ neg. ☐ pos., address of physician/hospital

In the event that your capacity to work is less than 100%, please answer questions a-c

a) Are you drawing benefits from an illness or accident insurer as a result of incapacity to work caused by illness or accident? ☐ Yes ☐ No

b) Have you been reported to the Swiss Federal Disability Insurance, to an Occupational Accident Insurer (e.g., SUVA) or to the Swiss Federal Military Insurance? ☐ Yes ☐ No

Are you drawing benefits from these institutions? ☐ Yes ☐ No

Decision already exists? ☐ Yes ☐ No

Please enclose copies of the decision, daily allowance statements, etc.

4 Previous pension scheme

With which employer were you last insured within the scope of the Occupational Benefits Scheme (pension scheme)?

Date of departure?

With which pension scheme/insurance company?

Address: Contract no.:

5 Declaration and consent of the person to be insured

With my signature I herewith confirm that I have answered the above questions fully and truthfully. By signing, I accept responsibility for all the information provided, even if the answers have been written by a third party.
I note that Helvetia is entitled to give written notice to terminate the contract if circumstances constituting significant risks have been either concealed or wrongly notified (Art. 6 of the Swiss Federal Law on Insurance Contracts VVG).
I hereby authorize Helvetia to process the data needed to check the application, process the contract or deal with claims. If necessary, the data may be notified to third parties involved in the performance of the contract both in Switzerland and abroad, in particular to co-insurers and re-insurers and to member companies of the Helvetia, Group for data processing. I hereby authorize Helvetia to obtain appropriate information from physicians, therapy providers, other medical personnel, medical institutions, authorities, other insurance companies and third parties. I specifically release the physicians, therapy providers, other medical personnel, medical institutions, authorities, insurance establishments and other third parties to whom enquires are made, together with their auxiliary staff, from their obligation of official, professional and contractual secrecy and I authorize them to provide Helvetia, in particular its medical service, with the information needed to check the application and settle claims. The data received may be used by member companies of the Helvetia Group and by their partner companies to submit offers of services that are appropriate to the needs in a particular case. My consent is given irrespective of the realization of the contact in question.

Place, Date

Signature of the person to be insured

Please return this form to: Your contracting office or Swisscanto Collective Foundation, Branch office, St. Alban-Anlage 26, P.O.Box 3855, 4002 Basle