COPRÉ

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

Adress: _____ 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: _____ %

(En cas d'activité à temps partiel, merci d'indiquer le salaire annualisé correspondant au taux d'activité effectif)

(If temporary or seasonal job, convert the split salary into 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 of more than 20%. (We'll 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: _____