

Notification of affiliation

Employer

Company name Contract no.

Personal details

Last name First name

Road / No. ZIP / Place

Date of birth Social security n°

Gender male female

Marital status single married since divorced widowed

registered partnership since dissolved partnership

Language German French Italian English

Group of insured persons Date of entry
(see designation of pension plan)

Annual salary AHV Degree of employment %
(projected for a whole year)

Is the person to be insured fully fit for work? Yes No

Does the person to be insured receive benefits from disability, military, or accident insurance or from a pension fund? Yes No

Place and date

Employer's stamp and signature