Medical examination

Swiss Life Ltd
Medical Services Corporate Business
P.O. Box
8022 Zurich

Employer	**Company**			
	Contract			
	Group of insured persons			
	Foundation	Swiss Life Collective BVG Foundation		
Employee	**Last name**			
	First name			
	Insured person's no.	756.	**Date of birth**	
	Street, no.			
	Post code, city			
	Telephone no.		**Gender**	☐ Man ☐ Woman
	E-mail address	@		

Applicant's declaration
Please answer each individual question with **"yes"** or **"no"**. For any question to which the answer is "yes" please give exact details of the time, duration, recovery, any lasting effects of illness and the address of the attending physician.

1. **In what sector (type of business) do you work?** ______

2. **What duties do you professionally perform?** ______

3. **Are you currently receiving medical treatment or under a doctor's supervision?** ☐ yes ☐ no
   If yes, why?
   ______
   Name, address of doctor / medical professional / hospital
   ______

4. **Are you taking regular medication or have you taken any in the last 5 years?** ☐ yes ☐ no
   If yes, why?
   ______
   What medication?
   ______
   Name, address of doctor / medical professional / hospital
   ______

5. **Is your capacity to work impaired in any way (fully or partially)?** ☐ yes ☐ no
   If yes, why?
   ______
   Name, address of doctor / medical professional / hospital
   ______

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6. **Have you been incapable of working (fully or partially) for a period of more than 3 weeks in the last 5 years?** ☐ yes ☐ no

Reason for incapacity to work

____

Name, address of doctor / medical professional / hospital

____

Date ________ (month/year) Start of treatment ________ (month/year) Duration ____ weeks

Full recovery: ☐ yes ☐ no

Any consequences: ☐ yes ☐ no If yes, what? ______________________________

7. **Have you been examined, treated or operated upon in hospitals or other facilities run by physicians during the last 10 years?** ☐ yes ☐ no

Type of health problem / treatment / operation?

____

Name, address of doctor / medical professional / hospital

____

Date ________ (month/year) Start of treatment ________ (month/year) Duration ____ weeks

Full recovery: ☐ yes ☐ no

Any consequences: ☐ yes ☐ no If yes, what? ______________________________

8. **Do you have any birth defects, physical handicaps, or injuries resulting from an accident?** ☐ yes ☐ no

If yes, what?

____

Name doctor / hospital to be contacted for information in this regard?

____

9. **Have you been in psychiatric or psychological treatment or consultation in the last 10 years?** ☐ yes ☐ no

Reason for treatment / consultation?

____

Name, address of doctor / medical professional / hospital

____

Date ________ (month/year) Start of treatment ________ (month/year) Duration ____ weeks

Full recovery: ☐ yes ☐ no

Any consequences: ☐ yes ☐ no If yes, what? ______________________________

10. **Have you consulted any other previously unmentioned doctors, chiropractors, osteopaths, physiotherapists, or other medical professionals in the last 5 years?** ☐ yes ☐ no

Reason for treatment / consultation?

____

Name, address of doctor / medical professional / hospital

____

Date ________ (month/year) Start of treatment ________ (month/year) Duration ____ weeks

Full recovery: ☐ yes ☐ no

Any consequences: ☐ yes ☐ no If yes, what? ______________________________

11. **Do you consume tobacco products or smoking articles?** ☐ yes ☐ no

☐ Cigarettes ☐ Cigars ☐ Pipe ☐ other, please specify? ____________

Since when? ____________ Amount per day ____________

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12. Do you take, or have you taken, any drugs in the last 10 years (incl. designer drugs)? ☐ yes ☐ no

If yes, what? ______________________

When was the last time? __________ How often? __________

13. Do you have any addictions, or have you had addictions in the last 10 years (medication, alcohol, etc.)? ☐ yes ☐ no

If yes, what? ______________________

When was the last time? __________ How often? __________

Attendant doctor? (name and address)

____

14. Have you undergone an AIDS test? ☐ yes ☐ no

If yes: the test result was ☐ HIV-positive ☐ HIV-negative

Attendant doctor? (name and address)

____

15. Do you or did you ever suffer from diseases, disorders or complaints affecting vision, such as subnormal visual acuity, weakness of vision, retinopathy or others? ☐ yes ☐ no

Correction (dioptres) left: ______ right: ______

Name doctor / hospital to be contacted for information in this regard?

____

16. Do you or did you ever suffer from diseases, disorders or complaints affecting hearing, such as impaired hearing, infections, tinnitus or others? ☐ yes ☐ no

Name doctor / hospital to be contacted for information in this regard?

____

17. What is your height? ______ cm

18. What is your weight? ______ kg

19. Are you in receipt (short-term disability benefit, pension etc.) of federal IV, MVG, UVG, BVG benefits, foreign social security benefits, or any other insurance benefits (e.g. a short-term disability benefit insurance), or have you claimed any benefits? ☐ yes ☐ no

For what degree of disability? ______ %

From whom:

____

Please enclose a copy of the documents for these benefits (e.g. current copy of the ruling(s), temporary disability benefit statement etc.)

20. Please name your family doctor/doctor who is best informed about your current health status.

Name and full address

____

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Insured person	**Last name**			
	First name			
	Insured person's no.	756.	**Date of birth**	
	Street, no.			
	Post code, city			
	Gender	☐ Man	☐ Woman	

Release form professional/official oath of secrecy and right to inspect documents

To the extent necessary for the provision of employee benefits (an underwriting risk assessment/processing of a specific insured event), the undersigned releases the federal disability insurance, federal military insurance, accident insurers, other and former employee benefits institutions, health insurers and short-term disability insurers and any foreign insurers, together with attending physicians, from their oaths of official or professional secrecy in dealings with Swiss Life and the foundation, and hereby authorises the above-mentioned institutions and persons to provide Swiss Life and the foundation with any information **(including medical information)** relating to employee benefits which may be required, and to allow Swiss Life and the foundation to see any relevant documentation. Only information which is specifically required will be obtained. In addition, the undersigned permits Swiss Life and the foundation to pass on his/her personal details and medical data within Swiss Life and to other insurers and reinsurers involved, for the purposes of assessing the claim to benefits and to combat insurance fraud. The undersigned also acknowledges that Swiss Life may engage third parties for data storage and data processing. The data will be treated in strict confidence by Swiss Life, the foundation and commissioned third parties and will be used exclusively for processing the pension or insurance contract, in accordance with the contractual agreement.

Signature

Person to be insured ________ ________________ ____________________

Date Place Signature

Incorrect or incomplete information may lead to Swiss Life or the Foundation refusing payment of benefits, or reducing the level of benefits within the framework of the legal stipulations.

Did you already have a limitation for pre-existing health conditions with your previous employee benefits institution? If yes, please enclose a copy of this limitation (medical definition, nature, beginning and duration).

Please return to: Swiss Life Ltd, Medical Services Corporate Business, P.O. Box, 8022 Zurich

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