



# Supplementary Information for Risk Assessment (Medical questionnaire)

Contract no.: \_\_\_\_\_  
Policy no.: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Street, no.: \_\_\_\_\_  
Zipcode, city: \_\_\_\_\_

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: \_\_\_\_\_  
OASI no.: \_\_\_\_\_ In the case of a foreign national: resident in Switzerland for \_\_\_\_\_ years.  
Place of citizenship (Swiss) or nationality (foreigners): \_\_\_\_\_

## 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
_____	_____	_____

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:**  
Helvetia Swiss Life Insurance Company Ltd, P.O. Box 3855, 4002 Basle