Health declaration

To be filled by the insured person

First name		Surname	
Street		Postal code, city	
Telephone		E-mail	
Date of birth		OASI Number	
Employer		Occupation	
Welfare institution			

Reason for enquiry

◯ New entry ◯ Wage adjustment ◯ New pension plan business

Health information

1. Are you fully fit to work? ◯ yes ◯ no

   If not, what is the extent of your inability to work? _____ %

   What is the reason for your inability to work? _____

2. If your answer to one of the following questions is **YES**, we would ask you to fill out the next page.

   2.1. Have you been fully or partially unfit for work for more than 3 weeks continuously during the last 5 years? ◯ yes ◯ no

   2.2. Have you, over the past 24 months, had more than 4 consultationsor instances of treatment with a physician or psychologist/psychiatrist (**not** including vaccinations, influenza, visits to the dentist and routine gynaecological check-ups)? ◯ yes ◯ no

   2.3. Are you currently undergoing treatment by a physician or psychologist/psychiatrist which has not yet definitively ended? ◯ yes ◯ no

   2.4. Have you, over the past 24 months, taken prescription drugs (apart from contraception) for longer than 4 weeks or had such drugs prescribed for you? ◯ yes ◯ no

   2.5. Have you consumed illegal drugs over the past 24 months? ◯ yes ◯ no

   2.6. Have you ever received pensions and/or daily benefits for more than 6 weeks due to illness or an accident? ◯ yes ◯ no

3. Has an HIV test ever produced the result of HIV positive for you? ◯ yes ◯ no

4. Please specify your height (_____ cm) and your weight (_____ kg).

5. Does or has your pension fund ever applied a reservation for health reasons or charged an additional premium? ◯ yes ◯ no

   If yes, for what reason? _____

   If yesi, please enclose a copy of the reservation/additional premiums.

Declaration

I hereby confirm that I have answered the above questions truthfully and completely. I authorise the doctors/physicians who treated and examined me, to disclose confidentially all information on my state of health needed to the medical services of the management of RV-Pool, c/o Beratungsgesellschaft für die 2. Säule and PKRück.

Place, date _____ Signature _____

Questions 2.1. to 2.3.

	What is/was the diagnostic, or which complaints do/did you have?	Since when?	Has the treatment been terminated?	Are there any consequences or are relapses/complications to be expected?	Name and address of the physicians / hospital providing treatment:
1			◯ yes, since ____ ◯ no		
2			◯ yes, since ____ ◯ no		
3			◯ yes, since ____ ◯ no		

Question 2.4.

	Name of the prescription drug?	Dose:	Since when?	Has the treatment been terminated?	Name and address of the physicians / hospital providing treatment:
1				◯ yes, since ____ ◯ no	
2				◯ yes, since ____ ◯ no	
3				◯ yes, since ____ ◯ no	

Question 2.5.

	Which illegal drugs have you consumed/do you consume?	How much and how often?	Please specify the duration.
1			
2			
3			

Question 2.6.

For what reason did you receive pensions and/or daily benefits? from: to:

Name and address of the physician who is best informed about your state of health:

Place: Signature: