Swiss Life Ltd, General-Guisan-Quai 40, P.O. Box, 8022 Zurich

SwissLife

Application for benefits on disability

Contract no. ______________________

Note
An application should be sent to us at the latest 1 month after expiry of the waiting period.

Details pertaining to the insured person

Name ______________ First Name ______________

Street, no. ______________ Postcode, Place ______________

Date of birth ______________ Telephone / mobile no. ______________

E-mail address ______________

Activity before occurrence of disability

Occupation ______________ Branch ______________

Precise activity ______________

○ full-time ○ part-time _______ hours per week ○ self-employed ○ employed

Name of employer/firm ______________

Address ______________

Do you have a job as a sideline? ○ yes ○ no

If yes, which ______________

Hours per week ______________

Cause of disability

On illness: Start ______________ Kind of illness ______________

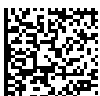
On accident: Date of incident ______________ Kind of injury ______________

Duration of disability

Extent and duration of disability _______ % from ______________ until ______________

_______ % from ______________ until ______________

_______ % from ______________ until ______________



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Medical treatment

Doctors treating you (when hospital please also mention department)

Start	Ende	Name, address

Which of these doctors can give information on the whole duration of the illness respectively results of the accident? ______________________

Are further therapists involved in the treatment? ○ yes ○ no

If yes: name, address ______________________

Remarks

____

____

____

____

Other registrations

My disability is also registered with — Benefits are approved

☐ disability insurance at ________ % since ________

☐ accident insurer at ________ % since ________

If yes: name, address ______________________

☐ Third party liability insurance at ________ % since ________

If yes: name, address ______________________

☐ further insurers at ________ % since ________

If yes: name, address ______________________

If pension fund/BVG insured with Swiss Life Contract no. ______________________

The examination of your claim to benefits is made easier if you provide us with copies of already existing doctor's reports and decisions of other insurers (disability insurance provisions, accident card, etc.).

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Authorisation

I am aware of the fact, that Swiss Life requires certain data concerning my personal details for the examination of the claim to benefits. Failure to provide this data can lead to rejection of the requested claim

I agree, that my personal details (name, first name, gender, date of birth, occupation, address) as well as my health details for the purpose of the examination of the claim to benefits can be handled by Swiss Life. Swiss Life can transmit these details for examination of the claim to benefits and for measures to combat insurance misuse, to affiliated companies as well as other participating insurers and reinsurers inland and abroad.

I am also in agreement, that Swiss Life can obtain information concerning the examination to the claim to benefits from affiliated companies as well as governmental offices and from third parties, especially from primary insurers regarding previous claims history.

I hereby release hospitals, doctors, psychologists, therapists and relevant staff of health insurers, short-term disability benefit insurers, health and accident insurers, AHV and IV offices, life insurers, pension funds, reinsurers and other third parties who are able to provide information in connection with the occurrence of the claim, from their duty of professional secrecy or confidentiality and authorise them to make records available for inspection and to disclose such information to Swiss Life, as is required to assess the case, and in particular to investigate the claim for insurance benefits.

I further authorise Swiss Life to transmit information and documents (incl. medical records and files available to us from other insurance companies involved) to other insurers, such as to health insurers, short-term disability benefit insurers, health and accident insurers, AHV and IV offices, life insurers, pension funds and reinsurers, as well as to experts and physicians, for the purpose of processing benefits. In order to combat insurance fraud, Swiss Life may forward this data to other Group companies and to third parties.

Policy/Reference no. ______________________

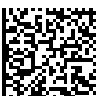
Name ______________________ First name ______________________

Place, date ______________________ Signature of the insured person ______________________

Tax notification (according to the federal law on withholding tax dated 13.10.1965)

Life insurance companies are obliged to report benefits on disability to the Swiss Federal Tax Administration, as long as the yearly annuity exceeds the amount of CHF 500.00. If objection is raised against this, Swiss Life is obliged to deliver 15% of all reportable benefits on disability charged to the insured benefits, without thereby declaring the name of the person entitled to benefits.

If we do not hear from you to the contrary, a tax notification will made.



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Payout

Payment to the following financial institution:

○ **Financial institution in Switzerland**

IBAN ______________________

Name of financial institution ______________________

Account holder (nat./leg. person [1]) ______________________

Residential address/domicile of account holder (if different to policyholder) ______________________

○ **Financial institution in Europe**

IBAN ______________________

Name of financial institution ______________________

Address of financial institution ______________________

Country of financial institution ______________________

Account holder (nat./leg. person [1]) ______________________

Residential address/domicile of account holder (if different to policyholder) ______________________

○ **Financial institution outside Europe**

Bank account no. ______________________

SWIFT code ______________________

Name of financial institution ______________________

Address of financial institution ______________________

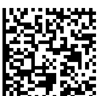
Country of financial institution ______________________

Account holder (nat./leg. person [1]) ______________________

Residential address/domicile of account holder (if different to policyholder) ______________________

[1] With operative controlling persons/business partnerships, the form "Identification of the controlling persons of legal entities/partnerships" shall be submitted.

With domiciliary companies (non-operative controlling persons/partnerships) the form "Ascertainment of beneficial owner" shall be completed through the applicant/policyholder.



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If the payment recipient is not the person entitled under the contract, the following information is also required:

Entitled person (nat./leg. Person)

Last name, first name/company ____________________

Residential/domicile address ____________________

Date of birth/foundation ____________________

Nationality/country of domicile ____________________

Place, date

Signature

Signature of pledgeholder (if contract is pledged)

The pledgeholder authorises Swiss Life to remit all payments on disability to the policyholder.

Place, date

Signature of pledgeholder

(Last name and first name of the signatories)

- The payment instructions can also be confirmed in a separate letter.
- If the entitlements arising from the contract are no longer pledged, a written notification of repeal should be submitted to us.