

# ÖKK LOSS OF EARNINGS INSURANCE

## Transfer to individual insurance

### Applicant details

First name:	Last name:	<input type="checkbox"/> f <input type="checkbox"/> m
Street, no.:	Post code, place:	
Telephone:	E-mail address:	
Date of birth:	Nationality:	
Marital status: <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> widowed		

### Previous employer

Company:	Policy no.:
Street, no.:	Post code, place:
Subject to CBA: <input type="checkbox"/> yes <input type="checkbox"/> no	
Name of CBA:	
Work carried out:	
Joined company:	Left company:
Annual salary (CHF):	(enclose copy of last pay slip)

### Employer confirmation

The employer hereby confirms that the above-mentioned information is correct.

### Employer's obligation to provide information

The employee has been informed of their rights and obligations under the General Insurance Conditions (employer's obligation to provide information) on: \_\_\_\_\_

Place/Date:	Signature of employer:
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## Additional questions to employee

Are you currently able to work?	<input type="checkbox"/> yes <input type="checkbox"/> no
Were you unable to work when you left the company?	<input type="checkbox"/> yes <input type="checkbox"/> no
If yes, since when?	Inability to work in %:
Have you moved job to a new employer?	<input type="checkbox"/> yes <input type="checkbox"/> no
If so, to which?	From when?
Agreed salary (CHF):	(enclose copy of pay slip or employment contract)
After leaving the company, will you be self-employed?	<input type="checkbox"/> yes <input type="checkbox"/> no
If so, doing what?	From when?
Have you applied to receive an unemployment daily allowance?	<input type="checkbox"/> yes <input type="checkbox"/> no
If so, with which unemployment insurance fund?	(enclose confirmation of amount of the insured daily allowance)
Are you responsible for the care of any children?	<input type="checkbox"/> yes <input type="checkbox"/> no
Are you drawing a pension allowance resulting from IV, MV, UVG, BVG or any other insurance policies?	<input type="checkbox"/> yes <input type="checkbox"/> no (If yes, please enclose a copy of confirmation of the pension entitlement)
Have you applied to receive pension benefits?	<input type="checkbox"/> yes <input type="checkbox"/> no
If so, with which insurance company/fund?	

## Declaration of consent

I hereby acknowledge that upon leaving the company, I have the right to transfer to ÖKK's individual insurance within 90 days. If I am entitled to subsequent benefits from the group contract of my previous employer, I can only transfer when I am medically certified as being able to work at a rate of at least 50% or by no later than when the obligation to pay benefits ends.

By signing this declaration, I hereby agree that I have answered all questions completely and truthfully.

Place/Date:	Signature:
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I have enclosed the following documents with this application:

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The conditions to be met in order to transfer and extend the insurance are based on the applicable law (KVG or VVG) as well as the applicable General Insurance Conditions (GIC).