Profmed & ProLibera
Fondation de prévoyance - Vorsorgestiftung - Fondazione di previdenza

EARNING INCAPACITY DECLARATION

Company: ....

INFORMATION CONCERNING THE PERSON INSURED

Last, first name: .... Date of birth: ....

E-mail: .... Telephone: ....

Address: ....

....

Which company is your:

- Health loss of earnings insurer: (name and address) ....

Accident insurer (LAA): (name and address) ....

and include daily benefit statements.

INFORMATION REGARDING EARNING INCAPACITY AND PROFESSIONAL SITUATION

Reason for the earning incapacity: ☐ illness ☐ accident

Degree and duration: .... % from .... to ....

.... % from .... to ....

.... % from .... to ....

Name and address of the attending physician:

....

and include medical certificates.

Professional situation:

- Professional activity pursued prior to the earning incapacity? ....
- Will the person insured be able to resume the same professional activity? ☐ yes ☐ no
- Has the employment contract been terminated? ☐ yes ☐ no If yes, when? ....

DECLARATION BY THE PERSON INSURED REGARDING EXEMPTION FROM THE OBLIGTATION TO MAINTAIN MEDICAL CONFIDENTIALITY

I, the undersigned, ... I authorise the post office or bank to return to the pension institution named in reference wrongly paid benefits and, when the entry has already been made, to place the amount to the debit of my account.

I have duly observed the notification to the federal contributions administration of the paid benefit.

Place, date: .... Signature of the insured: ....

Place, date: .... Stamp, signature of employer: ....