



## Health declaration to be filled out by the insured person

Company

Surname

First name

Date of birth

AHV (OASI) no.

Profession

Current occupation

- |   |              |    |
|---|--------------|----|
| 1. Are you currently suffering or have you, within the past five years, suffered from any illnesses or physical and/or mental disorders (whereas each and every impairment of health is to be declared, excepting minor and temporary impairments that disappeared after a few days and have not reappeared since)? | Yes          | No |
| 2. Have you had any accidents in the last five years?   | Yes          | No |
| 3. Are you currently taking and/or have you, within the past five years, taken any pain relievers, sleeping pills, stimulants, controlled substances (drugs) or medication, on a regular basis? If yes, which one(s)?   | Yes          | No |
| 4. Do you consume alcohol regularly? If yes, how much per week?   | Yes          | No |
| 5. Do you smoke regularly? If yes, how much per week?   | Yes          | No |
| 6. Have you been subject to a health restriction imposed by any previous pension fund? If yes, please attach a copy of the letter explaining and defining the restriction.  | Yes          | No |
| 7. Are you in receipt of benefits under Swiss Federal Disability, Military or Accident Insurance, from a pension plan or the social security programme of a foreign country? If yes, please indicate which one (and enclose a copy of the official statement granting benefits).                                    | Yes          | No |
| 8. Is an action pending or was there an action (early detection or benefits-related) within the last five years, with one of the institutions listed above? If yes, with which one?   | Yes          | No |
| 9. Height in cm   | Weight in kg |    |

If you have answered YES to one or more of questions 1-3, the following information is to be listed here:

Question	Details of medical condition(s)/ disorder(s)/symptom(s)	From when to when?	Unable to work? from when to when?	Treated by: (doctor(s), therapist(s), hospital(s); include exact addresses)

Address of your general practitioner

I confirm that I have answered the above questions completely and truthfully. In the event of inaccurate or incomplete information being supplied, Profond may, if it so chooses, refuse to provide supra-obligatory pension insurance coverage on the basis of a breach of the duty of declaration. I authorise the doctors who have treated and / or examined me to provide all available information on my medical history and status, in confidence, to the medical service or company doctor of Profond, to the Profond Pension Fund and to its reinsurer(s) and company doctor.

Place

Signature of the person to be insured

Date