ptv cpat

Pensionskasse der Technischen Verbände
SIA Swiss Engineering BSA FSAI suisse.ing

Caisse de Prévoyance des Associations Techniques
SIA Swiss Engineering FAS FSAI suisse.ing

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Personal application for affiliation

Company No.: _____ Member No.: **(leave blank)** _____

Employer: _____

Person responsible: _____ Mail: _____

Street/No.: _____

Post Code/Place: _____ / _____

Phone No.: _____ / _____

Professional association: ☐ SIA ☐ Swiss Engineering ☐ BSA ☐ FSAI ☐ suisse.ing ☐ SwissTnet

_____

Person to be insured

Starting date of insurance: (1st/16th of a month) _____

Category of persons (PK): _____ Language: _____

Surname/First name: _____

Home address: _____ Place: _____

Date of birth: _____ Gender: ☐ male ☐ female

AHV-No.: 756. _____

Civil status: _____ Date of marriage: _____

Self-employed: ☐ New affiliation ☐ main occupation ☐ secondary occupation ☐ none

For self-employed: Voluntary BVG membership ☐ Yes

Salary details

Relevant AHV annual salary (extrapolated to a full year /according to the effective degree of employment)

CHF _____ (Monthly salary multiplied by 12 or 13)

Degree of employment: _____ %

Offer No.: _____ **Proposal No.:** _____

(complete only for new company affiliations or changes to the existing plan)

Employer's confirmation

Place and date: Employer's signature:

_____ _____

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Company / member No: _____

The confidential declaration must be sent back completed and signed within 30 days. Thank you very much.

Confidential declaration

1. Are you in good health and fully fit for work at present? ☐ Yes ☐ No
   If not, why not? _____

2. How high are the physical strains in your current position ☐ small ☐ medium ☐ high

3. Do you currently require, or have you required medical and/or psychological care in the past five years? ☐ Yes ☐ No
   If yes, why? _____

   Do you currently take, or have you been taking medication in the past five years (for longer than a moth)? ☐ Yes ☐ No
   Name and address of the persons giving treatment (physicians): _____

4. Have you needed to interrupt your professional activity for more than 10 days in the past five years or to change your occupation for health reasons? ☐ Yes ☐ No
   If yes, why? _____

   Name and address of the persons giving treatment (physicians): _____

5. Is there a medical reservation for current insurance benefits? ☐ Yes ☐ No
   If yes, with which benefit scheme and why? _____

6. Are you receiving disability benefits at present? ☐ Yes ☐ No
   Have you drawn disability benefits in the past? ☐ Yes ☐ No
   If yes, when, and why? _____

   Have you registered with the Federal Disability Insurance (DI), accident insurance scheme or a foreign insurance provider? ☐ Yes ☐ No
   What is the status of the procedure? _____
   Name and address DI / AI / insurer: _____

7. Have you made early withdrawals from a 2nd pillar benefit or vested benefit scheme for home ownership purposes and not yet repaid this sum? ☐ Yes ☐ No
   If yes: Amount of the early withdrawal: _____ Date: _____
   - mortgaged? ☐ Yes ☐ No
   If yes: mortgaged amount: _____ Date: _____
   Name of mortgage creditor: _____

8. In the past three years before joining our pension fund, have you made one-off contributions to an occupational pension scheme or received such contributions from your employer? ☐ Yes ☐ No
   If yes: Amount paid in: _____ Date: _____

9. Previous employer
   Name and address: _____

   Previous benefit scheme
   Name and address: _____

The medical service of the SIA Swiss Engineering BSA FSAI suisse.ing Technical Associations pension fund (PTV), Health & Medical Service AG, is authorised to procure information about the state of health of the person to be insured on joining the insurance scheme. In this connection, the person to be insured releases all the treating persons (physicians, psychotherapists, chiropractors) and medical institutions from professional secrecy and all other insurance companies from their duty of discretion. The validity of the insurance relationship depends on the accuracy of the information provided. Incorrect information may cause the PTV to decline to provide benefits or reduce them to the BVG minimum.

Place and date: _____

Signature of the person to be insured: _____

Name in block capitals: _____

Mail/mobile number in case of requests: _____