

EMPLOYER

Company name: _____

APPLICANT (to be completed by the employer)

If you are still a member of your former employer's pension fund pursuant to Art. 26a of the LPP (provisional retention following a reduction in or cancellation of federal disability benefits), you must provide us with documentation from that pension fund indicating the expected end-date of the retention period. You may join a new pension fund once the retention period has ended, provided that all membership conditions are still met.

Date of membership: _____ Date of birth: _____

Last name: _____ First name: _____

Marital status: single married registered civil partnership divorced* widowed*

* applies analogously to registered partners

AVS No.: _____ Date of marriage/registered partnership: _____

Sex: male female Spouse's date of birth: _____

Date entered Switzerland if foreign national: _____ Annual reference salary (calculated for a full year) : CHF _____

Language: French German English Employment rate: _____ %

Home address: _____

Name and address of previous employer: _____

Name and address of previous pension fund: _____

Place and date:**Employer's stamp and signature:****HEALTH DECLARATION (to be completed by hand by the applicant)**

1. When you became a member, did you suffer from full or partial incapacity for work? yes no
2. Do you suffer or have you suffered over the past 5 years from health or accident-related problems, an illness or a congenital disease? yes no
3. Do you receive disability (AI) benefits or have you or will you apply for benefits? yes no
If so, what is the disability rating as determined by the AI? _____ %
(enclose a copy of the AI decision)
4. Was there a reserve or additional premium for health-related reasons relative to your previous pension fund? yes no

I authorize the Fund's reinsurer to take account of this document. If I have answered "yes" to at least one of the four questions, I am aware that I will only be granted the minimum LPP risk coverage until I receive written confirmation from the Fund's reinsurer that coverage has been extended over the legal minimum.

I certify that I have answered the above four questions accurately and truthfully.

Place and date:**Signature of the applicant:**

Please return to:

Banque Cantonale Vaudoise
Prévoyance professionnelle
Case postale 300
1001 Lausanne