AVENA
Fondation BCV 2e pilier

Membership request

EMPLOYER

Policy No.:

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 healthor 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:**

This document is a translation of the original French document. Only the French version is authoritative.

Please return to:

AVENA Fondation BCV 2e pilier
c/o Banque Cantonale Vaudoise
Case postale 300
1001 Lausanne