Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Federal Department of Finance FDF

Central Compensation Office CCO
Disability insurance Office
for insured people living abroad

QUESTIONNAIRE FOR COMPLETION BY THE INSURED PERSON

Please return to: DI Office for People Living Abroad
Av. Edmond-Vaucher 18, P.O. Box 3100, CH-1211 Geneva 2
Fax +41 58 461 99 50, e-mail oaie@zas.admin.ch

NAME:	Date of birth:
Our ref:	

Important:

Please return the duly completed, dated and signed questionnaire (please print)

Phone number: _____

E-mail: _____

A. INFORMATION CONCERNING YOUR HEALTH RESTRICTIONS

1. Information about your state of health

a) Name and address of your current general practitioner:

b) Have you been examined by other physicians? (**full** name and address of the doctor or the hospital)

During What period (please specify dates)

For which medical condition(s)?

c) Which other doctor treated you in the past? (**full** name and address of the doctor or the hospital)

During what period (please specify dates)

For which medical condition(s)?

B. PROFESSIONAL AND ECONOMIC SITUATION

2. School, higher education, profession(s) learnt

a) Type/level of education/training (primary, secondary, higher, apprenticeships, on-the-job training, etc.):

b) Name and address of the school, college or professor :

c) During what period (please specify dates)

d) Certificate/Diploma obtained (e.g. VET-diploma [vocational education and training], other diploma, license etc.):

3. Employment situation before your health restrictions:

- ☐ Full-time: as an employee or self-employed
- ☐ Part-time: as an employee or self-employed
- ☐ No gainful activity
- ☐ Other: _____

4. If you resigned your professional activity for health reasons :

What was your professional activity before making this application?

a) Please describe your last job in detail (field of activity, work posture, e. g. sitting/standing/alternate positions, load carrying):

b) During what period (please specify dates)

c) How many weekly hours were you working? _____

d) What was your gross monthly income?_____

e) If you were employed, please write your employer's name and address (street, number, postcode and town/city):

f) If your last job was in Switzerland, which Swiss pension fund ("second pillar") were you affiliated to when you became incapacitated for work? Please write the name and address of your Swiss pension fund.

5. If you are currently employed or self-employed:

a) Please describe your last job in detail (field of activity, work posture, e. g. sitting/standing/alternate positions, load carrying):

b) How many weekly hours are you working? _____

c) What is your gross monthly income? _____

d) Name and address of your employer (street, number, postcode and town/city) :

e) Since when? (please specify date):_____

6. If you reduced or increased your normal working hours:

a) For what reason? (health, economic choice, leisure, other reason)?

b) Since when? (please specify dates):_____

c) How many hours do you currently work per week?_____

d) What is your gross monthly income?_____

e) How many weekly hours were you working before the reduction/increase?_____

f) What was your gross monthly income before the reduction/increase?_____

7. If you have interrupted your professional activity/gainful occupation:

a) During which period? (please specify dates):

b) For what reason?

8. **If you have an accessory activity:**

a) What activity is it?

b) Since when? (please specify dates):_____

c) How many hours per week?_____

d) What is your gross monthly income?_____

e) Name and address of your employer (street, number, postcode and town/city):

9. If you do not work by personal choice:

a) What is your current occupation? (homemaker, studies, childcare, leisure, etc.):

b) Since when? (please specify dates):_____

c) For what reason?

10. If you were healthy, would you be working at the present time?

a) If not, for what reason?

b) If yes, what would be your activity?

c) For what reason? (financial, personal interest, other)?

d) Since when? (please specify dates):_____

e) What percentage of full-time hours would you be working?_____ %

11. Have you been seeking work?

a) If not, for what reason?

b) If yes, what kind of work?

c) For what reason? (financial, personal interest, other)?

d) Since when? (please specify dates):_____

e) What percentage of full-time hours would you be working?_____ %

f) By what kind of employers?

12. Have you received unemployment benefits?

a) Fully unemployed
During which period? (Please specify dates)

b) Part-time unemployed
During which period? (Please specify dates)

How many hours?

Per day	per month:

Name and address of unemployment benefit fund:

13. Are you currently in a training/formation?

a) What training/formation?

b) How many weekly hours?

14. Overall financial situation of the household:

Income	Currency	Amount (per month)	Remarks
Salary	…….....	……	…….....….....
Spouse's/partner's salary	…….....	……	…….....……
Child support and alimony	…….....	……	…….....……
Total pensions	…….....	……	…….....……
Social assistance	…….....	……	…….....……
Other income	…….....	……	…….....……
Expenditures			
Rent	…….....	……	…….....
Mortgage	…….....	……	…….....……
Debts	…….....	……	…….....……
Child support and alimony	…….....	……	…….....……
Other expenses	…….....	……	…….....……

15. Please describe your typical daily routine before your health impairment:

16. Please describe your typical daily routine since your health impairment:

C. PERSONAL SITUATION

17. Household composition

Total number of person(s) in the household: _____

Adults (how many and age of each one): _____

Children (how many and age of each one): _____

Members requiring permanent care (How many and age of each one):

_____

Employment rate (in %) of spouse/partner: _____

Has your spouse/partner had to reduce his/her working hours to help you because of your health impairment? _____

If so, since when and by how much has he/she reduced his/her activity (in %)?

_____

If you were a full-time employee or self-employed (see question 3), go directly to point 20. Otherwise, please fill in part D below.

D. HOUSEHOLD

18. Type of accommodation:

☐ Single-family house ☐ Farmhouse number of floors _____

☐ Flat/apartment floor_____ lift/elevator: ☐ yes ☐ no

Number of rooms:_____ square metres:_____

☐ Garden _____ (square metres) ☐ flower garden

☐ vegetable garden

☐ fruit trees

☐ other: _____

Flooring: ☐ Parquet ☐ tiled ☐ carpeted ☐ other_____

19. Home appliances :

☐ Washing machine

☐ Tumble dryer

☐ Dishwasher

☐ Freezer

☐ Microwave

☐ Vacuum cleaner

☐ Sewing machine

Do you have any vehicle? ☐ No ☐ Yes (what kind?)_____

Distance to the shops:_____ km

Explanatory notes about the two household-activity-tables below.

- For each item, indicate the average time per week spent, both before the health impairment and after.
- The time spent by the insured person and other persons in the same household (see point 17 above) must be indicated in Table 1.
- The time spent before the health impairment and/or after by any persons **outside** the household should be indicated in Table 2 below, if this is regular assistance.
- If necessary, take one or two weeks to record the time spent on the different tasks in order to help you fill in the tables.

Table 1: Insured person and persons in the same household according to point 17.	**BEFORE** the health impairment – **In the past**			**AFTER** the health impairment – **Current situation**		
Chores	**Time spent**	Time spent by other people in the household		**Time spent**	Time spent by other people in the household	
Food Meal planning Preparing vegetables Cooking (standing at cooking stove) Setting/clearing the table Washing dishes by hand Loading/unloading the dishwasher Putting dishes away Daily cleaning (work surface, cooker, table)	_____**hrs/week**	_____hrs/week	Who helps? : _____	_____**hrs/week**	_____hrs/week	Who helps? : _____
Upkeep of household **Daily cleaning** Daily tidying/dusting/airing Daily cleaning of sanitary facilities (bathroom) Making beds Waste/recycling **Periodic cleaning (incl. windows, doors)**	_____**hrs/week**	_____hrs/week	_____	_____**hrs/week**	_____hrs/week	_____
Shopping Preparation (checking supplies, making shopping lists) Daily shopping (fresh produce, daily requirements) Bulk buying (for heavy items) Administration (mail, payments) Going to offices, post office, bank, doctor, etc.	_____**hrs/week**	_____hrs/week	_____	_____**hrs/week**	_____hrs/week	_____
Laundry and clothing care Washing (sorting, transport, starting the machine) Hanging up and taking down laundry Ironing, folding, putting away clothes Minor mending jobs Cleaning shoes	_____**hrs/week**	_____hrs/week	_____	_____**hrs/week**	_____hrs/week	_____

Table 1 (continued)	**BEFORE** the health impairment – **In the past**			**AFTER** the health impairment – **Current situation**		
Chores	**Time spent**	Time spent by other people in the household		**Time spent**	Time spent by other people in the household	
Caring for and assisting relatives ***Generally no more than 30 hours per week*** **Children** Small children (lifting, changing diapers) Teaching, supervising and monitoring children Playing, doing arts and crafts, telling stories Leisure activities (excursions, park, cinema, swimming pool) Conversations Helping with homework Helping with learning Having discussions with parents at school/learning Children's events Taking children to doctor, dentist, etc. **Adults requiring care** Care (tasks of daily living) Taking them to the doctor, dentist, etc. Administration (mail, payments) Conversations	_____**hrs/week**	_____hrs/week	Who helps? : _____	_____**hrs/week**	_____hrs/week	Who helps? : _____
Outdoor and garden maintenance Maintenance of plants/lawn in the home and on the balcony Cleaning and maintenance of the environment **Pets** Feeding, cleaning, going to the vet Number of pets: _____ What pet?:_____	_____**hrs/week**	_____hrs/week	_____	_____**hrs/week**	_____hrs/week	_____
Hobbies _____	_____**hrs/week**			_____**hrs/week**		

Table 2: Regular household help from individuals outside the home not living with the insured person (cleaning staff, home help, gardener, neighbours, acquaintances, etc.)

Chores (for a detailed breakdown of each category, see Table 1)	**BEFORE** the health impairment – **In the past**	**AFTER** the health impairment – **Current situation**
Food	**_____hrs/week**	**_____hrs/week**
Upkeep of household	**_____hrs/week**	**_____hrs/week**
Shopping	**_____hrs/week**	**_____hrs/week**
Laundry and clothing care	**_____hrs/week**	**_____hrs/week**
Caring for and assisting relatives	**_____hrs/week**	**_____hrs/week**
Outdoor and garden maintenance, pet care	**_____hrs/week**	**_____hrs/week**

20. Observations / comments:

NAME :	Date of birth:
Our ref.:	

Permission:

By signing this questionnaire the insured person gives authorisation to all relevant persons and offices, in particular to doctors, paramedics, hospitals, health insurance, employers, attorneys-at-law, trustees, public and private insurers, public authorities and private welfare organisations, to release to the Old-age and survivors' insurance scheme as well as to the Disability Insurance's services any information and document that may be necessary for the examination of my application and for granting of benefits, as well as for the purpose of exercise of the insurer's right of recourse against liable third parties against whom the insured person may have a claim to compensation due to the loss incurred.

I, the undersigned, hereby declare to have answered the above questions completely truthfully. I understand that benefits granted based on inaccurate information or statements will have to be refunded.

Place and date: _____

Signature: _____