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 THE REVISION OF THE DISABILITY PAYMENT

Please return to : DI Office for people living abroad OAIE,
Av. Edmond-Vaucher 18, POB 3100, 1211 Geneva 2, Switzerland

Name :	DOB :
Our ref. :	

Important :

Please fill in the questionnaire completely and precisely. Please print clearly, sign and date.

Insuree's phone number: _____

E-mail address: _____

1. MEDICAL INFORMATION SINCE THE LAST REVISION / SINCE APPROVAL OF DI BENEFIT

Are you currently undergoing medical treatment? If so, which treatment by which doctor? Please add

2. ECONOMIC INFORMATION SINCE THE LAST REVISION/SINCE APPROVAL OF DI BENEFIT

a) Have you been or are you currently gainfully employed/self-employed after .....?

☐ No (*You may date and sign the questionnaire directly in Section 3 and return it to us.)*

☐ Yes : Beginning of contract/work on
End of contract/work on or ☐ contract not terminated.

Work(ed) as ☐ Employee
☐ Self-Employed/independent
☐ Volunteer / in sheltered workshop

Percentage of activity : __ % ☐ full-time
☐ part-time

If part-time, what was the reason?

b) Working hours and revenue :

Daily working hours : _____ Weekly working hours : _____

Gross hourly wages : _____ Gross monthly wages : _____

c) Briefly describe your activity and then answer the additional questions at the end of this questionnaire:

d) Name and address of the employer (Street/Street number, postal code, town/city, E-mail address :

e) If you were forced to interrupt your activity due to sickness or accident, please indicate how and for which period your activity was affected (please send attestation)

f) Have you given up your activity due to these interruptions? Since when?

g) Do you receive benefits from other types of Swiss insurance (accident insurance, the Swiss National Accident Insurance Fund (SUVA), a Swiss occupational retirement fund, life insurance, etc.)?

☐ yes ☐ no

Insurance name:

Insurance address:

Reference number:

3. OTHER REMARKS :

The insuree declares to have completely and truthfully answered the questions on this questionnaire.

Place and date :

Signature :

4. ADDITIONAL QUESTIONS : DESCRIPTION OF THE INDIVIDUAL ACTIVITY

The information you are giving us is extremely important. Indeed it will allow the medical service to optimally evaluate your situation.

For the following questions, please indicate the main tasks given to you as accurately as possible. Include a job description and what the requirements are to fulfill this job.

Which tasks make/made part of your job ? properly?	**What is the frequency of these tasks to be performed (on the basis of 8 hours/day)**		
	up to ½ h **seldom**	bet. ½h to 3h **occasionally**	bet. 3h to 5¼ h **often**
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

What requirements were you faced with concerning the physical/intellectual workload?	**What is the frequency these requirements were needed?** (on the basis of 8 hours/day)		
Physical	up to ½ h **seldom**	bet. ½h to 3h **occasionally**	bet. 3h to 5¼ h **often**
seated	☐	☐	☐
walking	☐	☐	☐
standing	☐	☐	☐
Lifting and carrying (light: 0–10 kg)	☐	☐	☐
Lifting and carrying (medium: 10–25 kg)	☐	☐	☐
Lifting and carrying (heavy: more than 25 kg)	☐	☐	☐
other	☐	☐	☐

Intellectual	**The daily demand is high**	**moderate**	**light**
concentration/attention to detail	☐	☐	☐
endurance	☐	☐	☐
Attention to detail	☐	☐	☐
Ability to understand	☐	☐	☐
other	☐	☐	☐

Other requirements :

Please indicate any additional information that you may find useful in giving us a more realistic picture of the work you are carrying out.