

Central Compensation Office CCODisability 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 : Our ref. :				DOB :	
I <u>mportant :</u>					
Please fill in the	e questionnaire com	pletely and precise	ly. Please p	orint clearly, sign and date.	
Insuree's pho	one number:				
E-mail addres	s:				
				SINCE APPROVAL OF DIE	
2. ECONOMI	C INFORMATION S	SINCE THE LAST F	REVISION/	SINCE APPROVAL OF DI BE	NEFIT
a) Have you be	een or are you curre	ntly gainfully emplo	yed/self-en	nployed after?	
No (You ma	ay date and sign the	questionnaire direc	ctly in Secti	on 3 and return it to us.)	
	nning of contract/wo of contract/work on	rk on	or	contract not terminated.	
Work(ed) as	Employee Self-Employed/ir Volunteer / in she				
Percentage of	activity: %	full-time part-time			

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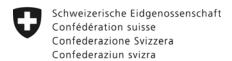
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If part-time, what was the reason?	
b) Working hours and revenue :	
Daily working hours :	Weekly working hours :
Gross hourly wages :	Gross monthly wages :
c) Briefly describe your activity and then answer the acquestionnaire:	dditional questions at the end of this
d) Name and address of the employer (Street/Street no	umber, postal code, town/city, E-mail address :
e) If you were forced to interrupt your activity due to significantly which period your activity was affected (please send at	
f) Have you given up your activity due to these interrup	otions? Since when?
e) If you were forced to interrupt your activity due to side which period your activity was affected (please send at	ckness or accident, please indicate how and for ttestation)

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g) Do you receive benefits from other types of Swiss insura National Accident Insurance Fund (SUVA), a Swiss occupa	
yes no	
Insurance name:	
Insurance address:	
Reference number:	
3. OTHER REMARKS:	
The insuree declares to have completely and truthfully answ	vered the questions on this questionnaire.
Place and date :	Signature :



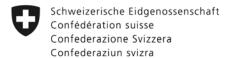
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4. ADDITIONAL QUESTIONS: DESCRIPTION OF THE INDIVIDUAL ACTIVITY

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 concer he physical/intellectual workload?		the frequency these asis of 8 hours/day)	e requirements were n	
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				
	The daily de			
Intellectual concentration/attention to detail	high	moderate	light □	
endurance				
Attention to detail				
Ability to understand				
other				



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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.					
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