

## **QUESTIONNAIRE FOR SELF-EMPLOYED**

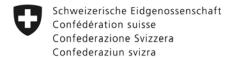
Please return to: DI Office for insured persons abroad, Av. Edmond-Vaucher 18, POB 3100, 1211 Geneva 2, Switzerland Fax +41 58 461 99 50, E-Mail: oaie@zas.admin.ch

Name :	DOB :
Our ref. :	
Important :	
Please, duly complete, date and sign this questionna	re (please print).
DESCRIPTION OF YOUR INDEPENDENT ACTIVIT	Y BEFORE YOUR HEALTH DETERIORATED
Name and address of the firm / corporation	
2. Please precisely describe your activity <b>before yo</b>	ur health deteriorated:
Kindly fill in paragraph 14 of the questionnaire	
3. Since what date have you been self-employed (d	d.mm.yyyy)??
Diagon submit the convert the registration with	the Degistry of Commerce and Commerce or
Please submit the copy of the registration with any other relevant documentation.	the Registry of Commerce and Companies or
4. Working hours <b>before your health deteriorated</b> daily week	
5. How much was your monthly income before you	r health deteriorated?
Please submit the tax forms/tax returns for the deterioration.	three fiscal years <u>prior to your health</u>

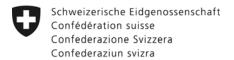
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Federal Department of Finance FDF

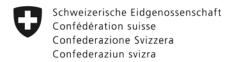
6.	Un	til what date we	ere you able to work wit	thout any re	strictions (dd.mm.yyyy)?
DE	SCR	RIPTION OF YO	OUR INDEPENDENT A	CTIVITY AF	TER YOUR HEALTH DETERIORATED
	Wo daily		er your health deterior	rated : weekly :	
			our monthly income <b>afte</b>		
Ple	ase	submit the tax	x forms/tax returns for	r the three t	fiscal years <u>after your health deteriorated.</u>
9.	Because your health deteriorated :				
	a)	Did you perfo	rm lighter work compare	ed to what y	ou previously were able to accomplish?
		☐ Yes	☐ No		
		If yes, which?			
Since when ?					
	b) Did you have to outsource work that you were previously able to accomplish personally?			eviously able to accomplish personally?	
	☐ Yes ☐ No				
		If yes, which?		Ad	ditional costs caused



	c) Did you have to employ additional salaried personnel?					
		☐ Yes, how many:	no			
		For which period? From (dd.mm.yyyy)	To (dd.mm.yyyy)			
		For how many hours weekly?				
		Salaries	Social security charges			
	d)	Did you have this personnel do the work  ☐ Yes ☐ No	that you were previously able to accomplish yourself?			
		If yes, which work?				
10.			Ith (please precisely indicate the periods, with e downtime and if this was partial or 100% downtime)			
	Please submit an attestation of your health- and/or accident insurer or the loss of income insurance.					
11.	11. Have you definitively given up your activity?					
	□ `	Yes				
	lf y	ves, since what date (dd.mm.yyyy)?				
Please submit the certificate of deregistration with the Registry of Commerce and Companies						



12. Are you receiving disability benefits from the social insurance of your country of residence?			
☐ Yes	□ No		
If yes, since wher			
Kindly attach th	he copy of the insurance decision		
13. Additional comm	nents		
I, the undersigned, questions.	hereby certify to have truthfully an	d completely responded to above	
Place and date :		Signature :	



## 14. ADDITIONAL QUESTIONS: DESCRIPTION OF THE INDIVIDUAL ACTIVITY

The information you are giving us here is of utmost importance. Indeed it will permit our medical services to process your request with optimum compliance.

For the following questions, please indicate the primary tasks and the requirements needed to accomplish your activity. Be as precise as you can.

What tasks make/made part of your workplace/your job description/activity	how often did these tasks have to be performed daily, based on an 8-hour-day			
	up to ½ hr seldom □	btwn ½h - 3hrs sometimes □	btwn 3hrs - 5¼ h often □	
With what requirements/physical and intellectual burdens were you confronted ?	how often did these requirements have to be performed daily, based on an 8-hour-day			
Physical	up to ½ hr seldom	btwn ½ - 3hrs b	twn 3hrs - 51/4 hrs often	
Sitting				
Walking				
Standing				
Lifting and carrying (light 0-10 kilos)				
Lifting and carrying (medium 10-25 kilos)				
Lifting and carrying (heavy over 25 kilos)				
Other				
		irements/burdens a	are	
Intellectual	high	average	low	
concentration/attention to detail			Ц	
endurance				
care				
Facility of understanding				
other				

Other requirements/burdens:

Please write down any additional information that may give us a more realistic picture of your activity			