

Central Compensation Office CCODisability insurance Office for insured people living abroad

QUESTIONNAIRE FOR INDEPENDENT FARMER

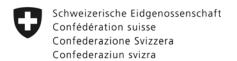
Please return to : DI Office for insured persons abroad, Av. Edmond-Vaucher 18, POB 3100, 1211 Geneva 2, Switzerland Fax +41 58 461 99 50, E-Mail : oaie@zas.admin.ch

Name	e :	DOB :
Our r	ref. :	
<u>Impor</u>	rtant:	
Please	e, duly complete, date and sign this c	uestionnaire (please print).
DESC	RIPTION OF YOUR INDEPENDENT	ACTIVITY BEFORE YOUR HEALTH DETERIORATED
1. Sir	nce what date have you been an inde	ependent farmer (dd.mm.yyyy ?
2. W	ho is currently in charge of this farm	?
	ease indicate the total surface of the m2 :	terrains of this farm (both, owned terrains and leased terrains)
•	Crop cultivation: m² Arboriculture (including nuts, olives Please specify the type of crop: vegetables and grains cultures: Please specify the type of crop: other cultures: m²	s and other fruits and berries): m ²

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Number of livestock	
• cattle :	• goats :
• sheep :	• porks :
• chicken :	• other :
Agricultural machinery	
Type :	Number :
Current value of your machinery (please inc	dicate currency)
Please precisely describe your activity befo	re your health deteriorated:
	•
Kindly fill in paragraph 15 of the question	nnaire
a) Your working hours before your health det	
daily:	weekly:
b) How much was the net income before your	health deteriorated:
•	
Year 	Amount (please indicate currency)
Please submit the tax forms/tax retudeterioration.	rns for the three fiscal years <u>prior to your health</u>

4.



5.		With the exception of yourself, how many persons were working on your farm before your health deteriorated?			
	Fan	nily members:			
	Em	ployees :			
		what period / season? m (dd.mm.yyyy)	to (dd.mm.yyyy)		
	For	how many hours weekly?			
RI	 EDU	il what date were you able to work full-tim CTION / CESSATION OF THE INDEPEN	e without any restrictions (dd.mm.yyyy)?		
		cause your health deteriorated:			
	a)	you had to give up certain activities on y yes no	our farm?		
		If yes, what activities ?			
	b)	did family members have to increase the yes no	eir collaboration?		
		If yes, which family member(s) and for which activities?			

8.

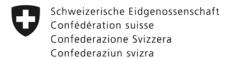
9.

10.

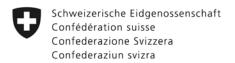
Federal Department of Finance FDF

c) did you have to employ salaried	personnei?					
yes, how many persons:	no					
If yes, for what period / season? From (dd.mm.yyyy)	to (dd.mm.yyyy)					
During how many hours weekly?	Ouring how many hours weekly?					
Wages	Social security charges					
How much was the net income of this fa	arm after your health deteriorated:					
Year	Amount (please indicate currency)					
Please submit the tax forms/tax return deteriorated.	ns for the three fiscal years <u>after your health</u>					
What work are you still able to accomplis	sh personally?					
For how many hours daily?						
What work are you unable to accomplish	n because your health deteriorated?					

11.	Have you definitively yes	given up your activity? no	
	If yes, on what date	(dd.mm.yyyy) ?	
ΑD	DITIONAL ACTIVITY	,	
12.	Lucrative activity besi	ides farming. Please desc	cribe this activity:
	self-employed		employed by (Company/ name/ address) :
			employed by (Company/ name/ address) :
	Please accurately de	scribe this activity besides	s farming :
	For what period / sea From (dd.mm.yyyy)	son?	to (dd.mm.yyyy)
	How many hours wee	ekly/monthly/yearly?	
	Monthly/yearly incom	e generated by this additi	onal activity:
	What was the reason	for giving up this addition	nal activity?



13. Are you rec	eiving disability benefits f	from the social insurance of your country of residence??
yes	no	
If yes, since	when (dd.mm.yyyy)?	
Kindly attac	ch the copy of the insur	ance decision
14. Additional c	omments:	
I, the undersign	ed, hereby certify to have	e truthfully and completely responded to above questions.
Place and d	ate:	Signature :



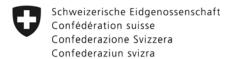
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15. ADDITIONAL QUESTIONS: DESCRIPTION OF THE INDIVIDUAL ACTIVITY

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.

With what requirements/physical and intellectual burdens were you confronted? Physical Sitting Walking Standing Lifting and carrying (light 0-10 kilos) Lifting and carrying (heavy over 25 kilos) Other The daily requirements/burdens are High average low Concentration/attention to detail Endurance Care Facility of understanding	What tasks make/made part of your workplace/your job description/activity	how often do these tasks have to be performed daily, based on an 8-hour-day			
intellectual burdens were you confronted? performed daily, based on an 8-hour-day up to 1/2h seldom sometimes often Sitting Walking Standing Lifting and carrying (light 0-10 kilos) Lifting and carrying (heavy over 25 kilos) Other The daily requirements/burdens are High average low Concentration/attention to detail Endurance Care Facility of understanding					
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Standing Lifting and carrying (light 0-10 kilos) Lifting and carrying (medium 10-25 kilos) Lifting and carrying (heavy over 25 kilos) Other The daily requirements/burdens are High average low Concentration/attention to detail Endurance Care Facility of understanding					
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The daily requirements/burdens are Intellectual Concentration/attention to detail Endurance Care Facility of understanding	Lifting and carrying (heavy over 25 kilos)				
Intellectual High average low Concentration/attention to detail Endurance Care Facility of understanding	Other				
Endurance Care Facility of understanding	1				
Care Facility of understanding					
Facility of understanding	Endurance			<u> </u>	
	Care				
	Facility of understanding				
Other	Other				



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