

1.

Central Compensation Office CCODisability insurance Office
for insured people living abroad

QUESTIONNAIRE FOR THE EMPLOYER

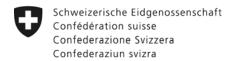
Please return to : DI Office for insured persons abroad, Av. Edmond-Vaucher 18, POB 3100, 1211 Geneva 2, Switzerland Fax +41 58 461 99 50, E-Mail : oaie@zas.admin.ch

Name : Our ref. :		DOB:		
Important :				
Please, duly complet	e, date and sign this	questionnaire (please print).		
INFORMATION ABOU	IT THE FIRM / CORPO	PRATION		
Name and address of the firm / corporation :				
Contact person, in case Name, first name	e we have additional વૃા	uestions		
phone number	fax number	E-mail address		
INFORMATION ABOUT THE EMPLOYMENT CONTRACT				
Beginning and ending of Beginning (dd.mm.yyyy				
Please submit the cop	py of the employment	contract		
The contract is				
for an indefinite per	riod	for a fixed-term period		
		Ending by (dd.mm.yyyy) :		
terminated	current			
Has the employee bee	n hired after he/she wa	s recognized as invalid/disabled		
Yes	No			

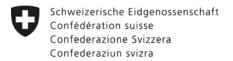
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2.	Who terminated the working contract?
	For what motivation ?
3.	Last effective day of work (dd.mm.yyyy)
4.	DESCRIPTION OF THE ACTIVITY BEFORE THE HEALTH DETERIORATED Detailed description of the activity performed by the insured before his/her health deteriorated
	Kindly complete paragraph 7 of this questionnaire light physical medium physical heavy physical
	activity level activity level activity level
	Is this job particularly exposed to stress, noise, the cold, vapors, aso)?
	full-time work part-time work in percentage terms : %
	What was the motivation for part-time work (reduction of professional work because of health issues, economic reasons, personal reasons, other):



What are t	he regular v hours daily	vorking hours on number	of your company of hours weekly		
Working he Daily work			ore the health deto vorking hours	eriorated starting from	(dd.mm.yyyy)
Income Gross hou	rly income	Gross	s monthly income	Gross yearly inc	come
Please su	bmit the th	ree most rece	ent salary stubs <u>p</u>	rior to the health deterioration	ng.
Is the cost benefits in	for food an kind?	d housing reim	bursed? Reimburs	sement of other expenses, soc	ial benefits or
yes if yes, corr	responding	no to approximate	ly what amount?		
other impo	rtant details	s/remarks:			
Absences below.	: You may a	also submit a p	rintout/list of abser	nces. In this case, please disre	egard this list
Absent bed	cause of: S	= sickness / A	A = accident (pleas	se specify)	
S/A	year	from	to	in percentage to	erms

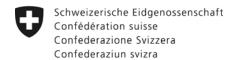


5.

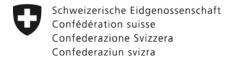
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REDUCTION OF THE ACTIVITY AFTER THE HEALTH DETERIORATION

Please respond to the following questions, if the employee had to assume lighter work within your firm:					
Detailed description of the activity after the health deteriorated					
The employee can no longer perform the following activities:					
Since when ? (dd.mm.yyyy)					
full-time part-time in percentage terms : %					
Working hours of the employee after the health deteriorated Daily working hours Weekly working hours since what date (dd.mm.yyyy)					
Salary after the health deteriorated Gross hourly salary Gross monthly salary Gross yearly salary					
Please submit the three most recent salary stubs after the health deteriorated.					
Does the salary paid represent the compensation for the real work effort of the employee in ill health? yes no					
If not, what salary would correspond to the real work effort? Since when? Amount					
Does the salary paid include goodwill offers by the employer (because of family ties, moral obligation, aso)? yes no					
if so, to what extent?					



How much would the insured pe executed?	erson, in good health, gain t	today and with the activity previously		
Gross hourly salary	Gross monthly salary	Gain yearly salary	Gain yearly salary	
6. Other remarks:				
Place and date :		Signature :		



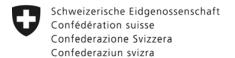
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7. ADDITIONAL QUESTIONS: DESCRIPTION OF THE INDIVIDUAL ACTIVITY

The information you are giving us here is of utmost importance. Indeed it will permit our medical services to process the insured person's 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 part of the workplace/job description/activity		How often do these tasks have to be performed daily, based on an 8-hour-day			
	up to ½ hr seldom	btwn 1/2h-3hrs sometime	btwn 3hrs-51/4hrs es often		
With what requirement/physical and intellectual burdens is the employee confronte		these requirements ly, based on an 8-h			
	up to ½ hr	btwn 1/2hr-3hrs	btwn 3hrs-5 1/4 hrs		
Physical I	seldom	sometimes	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					
Intellectual	The daily i	r equirements/burde average	ens are low		
concentration/attention to detail					
endurance					
care					
Facility of understanding					
Other					



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Other requirements/burdens: Please write down any additional information that may give us a more realistic picture of the employee's activity.