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 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 : | DOB : |
| Our ref. : | |

**Important :**

Please, duly complete, date and sign this questionnaire (please print).

## INFORMATION ABOUT THE FIRM / CORPORATION

Name and address of the firm / corporation :

Contact person, in case we have additional questions
Name, first name

| phone number | fax number | E-mail address |
|---|---|---|
| | | |

## INFORMATION ABOUT THE EMPLOYMENT CONTRACT

**1.** Beginning and ending of the employment contract

| Beginning (dd.mm.yyyy) | Ending (dd.mm.yyyy) |
|---|---|
| | |

**Please submit the copy of the employment contract**

The contract is

☐ for an indefinite period ☐ for a fixed-term period

Ending by (dd.mm.yyyy) : _____

☐ terminated ☐ current

Has the employee been hired after he/she was recognized as invalid/disabled

☐ Yes ☐ No

**2.** Who terminated the working contract ?

For what motivation ?

**3.** Last effective day of work (dd.mm.yyyy)

**DESCRIPTION OF THE ACTIVITY BEFORE THE HEALTH DETERIORATED**

**4.** Detailed description of the activity performed by the insured **before his/her health deteriorated**

**Kindly complete paragraph 7 of this questionnaire**

☐ light physical activity level ☐ medium physical activity level ☐ heavy physical 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 the regular working hours of your company

| number of hours daily | number of hours weekly |
|---|---|
| | |

Working hours of this employee **before the health deteriorated**

| Daily working hours | weekly working hours | starting from (dd.mm.yyyy) |
|---|---|---|
| | | |

Income

| Gross hourly income | Gross monthly income | Gross yearly income |
|---|---|---|
| | | |

**Please submit the three most recent salary stubs prior to the health deteriorating.**

Is the cost for food and housing reimbursed? Reimbursement of other expenses, social benefits or benefits in kind?

☐ yes ☐ no

if yes, corresponding to approximately what amount ?

other important details/remarks:

**Absences:** You may also submit a printout/list of absences. In this case, please disregard this list below.

Absent because of: **S = sickness / A = accident** (please specify)

| S/A | year | from | to | in percentage terms |
|---|---|---|---|---|
| | | | | |

**REDUCTION OF THE ACTIVITY AFTER THE HEALTH DETERIORATION**

**5. 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 <u>after the health deteriorated.</u>**

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 person, in good health, gain today and with the activity previously executed?

| Gross hourly salary | Gross monthly salary | Gain yearly salary |
|---|---|---|
| | | |

**6. Other remarks:**

Place and date :

Signature :

## 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 sometimes | btwn 3hrs-51/4hrs often |
| | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ |

| **With what requirement/physical and intellectual burdens is the employee confronted ?** | **How often do these requirements have to be performed daily, based on an 8-hour-day** | | |
|---|---|---|---|
| | up to ½ hr | btwn 1/2hr-3hrs | btwn 3hrs-5 ¼ hrs |
| **Physical** | 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 | ☐ | ☐ | ☐ |

| | **The daily requirements/burdens are** | | |
|---|---|---|---|
| **Intellectual** | high | average | low |
| concentration/attention to detail | ☐ | ☐ | ☐ |
| endurance | ☐ | ☐ | ☐ |
| care | ☐ | ☐ | ☐ |
| Facility of understanding | ☐ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ |

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