

Underwriting

To be completed by the employer

Broker/agent _____ (enclose broker mandate)

1. Employer

Company _____

Street/no. _____

Postcode/place _____

The employer confirms that the persons listed below may report changes in staffing with legally binding effect to Profond.

1.1 Main contact

This person automatically receives the activation code to log into the ProfondConnect company portal. This person can register additional users or delete or deactivate users on their own initiative.

Surname/First name _____

Position _____

E-mail _____

Mobile number _____

1.2 Additional person (e.g. a broker)

Surname/First name _____

Position _____

E-mail _____

Mobile number _____

The employer's main contact person must have registered in ProfondConnect. After this point in time, Profond can capture the logins and rights for the person specified in Point 1.2. Do you want us to do this for you?

Yes No

Please select the desired individual ProfondConnect authorisation(s) (multiple selections are possible):

- Authorisation for **occupational retirement benefits** (reading and modification rights), i.e. access to the management of the insured
- Authorisation for **accounting** (read and modification rights), i.e. access to all invoices and payment documents
- Authorisation for **connect-administrators**, i.e. authorisation to record and delete/deactivate users

2. Previous insurer

Does the employer have a previous insurer?

Yes If yes, please go to Point 2.1.

No If no, please explain:

Start-up

No BVG obligation

2.1 Current pension solution

Insurer/foundation _____

Contract number _____

End of contract [.]

Contract terminated as of [.]

Contact person at the previous insurer:

Surname/First name _____

E-mail _____

Following affiliation with Profond, does the employer have further pension solutions with other pension funds? Yes No

3. a) Collective sickness benefit insurance

Does a collective sickness benefit insurance with cover of at least 80 per cent of the insured annual salary exist for 720 days with full cover (BVG-coordinated)? Yes No

If yes, please specify with which company:

Insurance company _____ Policy no. _____

3. b) Accident insurance

Your accident insurance provider:

Insurance company _____ Policy no. _____

4. Pending cases of incapacity to work

Are longer-standing cases of incapacity to work (> 1 month) currently pending? Yes No

If yes, please let us know how many: _____

5. Ongoing disability allowances

Are disability allowances currently being paid? Yes No

If yes, please let us know to how many persons: _____

6. Ongoing old-age and surviving dependants' pensions

Are old-age and/or surviving dependants' pensions currently being paid? Yes No

If yes, please let us know to how many persons:

No. of old-age pensioners: _____ No. of surviving dependant pensioners: _____

7. Regulation on the assumption of pensions according to the current affiliation agreement

Regardless of whether there are ongoing pension cases, please indicate how any assumption of pensions is regulated with your previous insurer in the current affiliation agreement:

- Recipients of old-age and survivors' pensions remain with the previous insurer
- Recipients of old-age and survivors' pensions must be taken over by the new pension fund
- There is no regulation in this regard

Confirmation

By signing this form the employer confirms the accuracy and completeness of the information provided.

Place, date

Legally valid (collective) signature(s) according to the commercial register



Documents

Please enclose the following documents if you have not already lodged them:

- Current and detailed directory for pensioners (as an Excel file)
- Overview of the claims history of the last 5 years (cases of incapacity to work)
- Broker mandate