Please complete and return to:

Baloise Life Ltd
Aeschengraben 21
P. O. Box
4002 Basel

Death report

Form for survivors

Contract no. **50 /** .....

Company pension plan: .....

1. Information about the insured

Policy no. **51 /** .....

Last and first name .....

Street .....

Postcode / town .....

Date of birth .....

a) Marital status of the insured at time of death:
(Please indicate as appropriate)

☐ Married or in registered partnership. Date of marriage / registration: .....

☐ Divorced or registered partnership dissolved.

☐ Widowed

☐ Single

b) Was the deceased involved in a marriage like relationship at the time of death? ☐ Yes ☐ No

For a unmarried insured involved in a marriage-like relationship at the time of death:

- Municipal certificate of residence for the past five years for the insured;
- Municipal certificate of residence for the past five years for the surviving partner;
- Registry office extract for the surviving partner;
- Registry office extract for children of both partners.

c) Was the insured ever divorced, or was a registered partnership ever dissolved? ☐ Yes ☐ No

d) Name, date of birth, AHV number and address of all (including former) spouses and registered partners:

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If one or more marriages or registered partnerships lasted longer than ten years and a maintenance obligation (annuity or lump-sum) was declared at the insured's expense in the divorce or dissolution decree, please attach copies of the following documents:

- Divorce decree including joint petition for dissolution or corresponding documents related to dissolution of a registered partnership;
- AHV/AVS pension notice and any notice from the UVG/LAA insurer.

e) Name, birth date and AHV number of children of the insured:

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For adolescents between ages 18 and 25 who have not finished education/apprenticeships or are permanently disabled: please enclose confirmation from the employer or school/university or the IV/AI pension notice.

2. Health-related work incapacity before death

Was the insured unable to work for health reasons for more than three months before death?
(Please indicate as appropriate)

☐ No

☐ Yes → at ..... % starting .....

Name and address of last doctor: .....

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If a doctor's certificate with diagnosis and case history is available: please enclose or provide the name and address of the insurance company to which it was sent.

3. Information on the death

Date of death: .....

Cause of death: *(Please indicate as appropriate)*

☐ Infectious disease	☐ Respiratory disease	☐ Suicide
☐ Cancer	☐ Metabolic disease	☐ Mental illness
☐ Circulatory system failure	☐ Traffic accident	☐ AIDS
☐ Gastrointestinal failure	☐ Other accidents, homicide	☐ Drugs

☐ Other causes: .....

Important – please enclose:

- Official death certificate;
- Registry office extract or copy of the insured's complete family register;
- Address of the office or attorney responsible for settlement of the estate;
- Grant of probate.

4. Remittance of benefits (if any)

Postal account no. .....

Account holder
(first and last name) .....

or

Name and address of bank .....

IBAN .....

Clearing no. .....

Account holder
(first and last name) .....

5. Survivors' address

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6. Remarks

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The undersigned hereby confirms that the information given here is accurate and complete.
The undersigned authorizes Baloise Life Ltd (hereinafter "the Baloise") to process the insured's data in connection with the verification and processing of this insurance claim/benefit case. The Baloise may in particular:

- Transmit data to involved third parties in Switzerland or abroad (e. g. co-insurer, reinsurer);
- Seek recourse from a liable third party (or their liability insurer) and provide them with the relevant data;
- Obtain relevant information and access to relevant documentation from medical practitioners (physicians, chiropractors, psychologists, service providers acting on the instructions of a physician, laboratories, hospitals, institutions offering outpatient or partial inpatient medical treatment, nursing homes), social insurers (AHV/AVS, IV/AI, UVG/LAA and KVG/LAMal insurance), private insurers, occupational benefit institutions, public offices, employers and other providers of relevant information.

The undersigned authorizes the above-mentioned individuals or institutions to provide the Baloise or Baloise's medical service, at the latter's request, with data required for the verification and processing of the insurance claim, and releases them from their obligation of secrecy for this purpose.

The undersigned also releases the Baloise from its obligation of secrecy with regard to data that it passes on to third parties in connection with the processing of the claim/benefit case.

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Place, date Signature