Withdrawal from Service Form

To be completed by the policyholder (foundation) or the employer

Contract No. Employee benefit institution

1. Surname First name

AHV-No.: 756.☐☐☐☐.☐☐☐☐.☐☐

Street Postal code/Town

2. Policy number

3. Is the person to be insured married? ◯ Yes, since (date): ◯ No

Is the person to be insured living in a registered partnership? ◯ Yes, since (date): ◯ No

4. Is the withdrawing person able to work? ◯ Yes ☐ Partially ◯ No

Is the withdrawing person in receipt of a disability pension? ◯ Yes (degree of disability:) ◯ No

5. Date of withdrawal: (last day of salaried employment)

Place and Date

Seal and signature of the policyholder (foundation) or employer

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