

## Registration with pension fund (BVG) by sole proprietorship

### Business address

**UID number:**

Name of business establishment: \_\_\_\_\_

C H E -

Street, Number: \_\_\_\_\_

P.O. Box: \_\_\_\_\_

Postcode, Town: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Website: \_\_\_\_\_

Sector: \_\_\_\_\_

Do you manage an agriculture business?

 Yes

 No

Self-employment as:

 Primary occupation

 Secondary occupation

Language of correspondence:

 German

 French

 Italian

Previous owner: \_\_\_\_\_

Date on which business was opened: \_\_\_\_\_

### Place of residence (tax domicile) of company owner

Surname(s): \_\_\_\_\_

First name(s): \_\_\_\_\_

Street, Number, P.O. Box: \_\_\_\_\_

Postcode, Town: \_\_\_\_\_

Insurance Number: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Telephone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

### Mailing address for business correspondence

Company name: \_\_\_\_\_

Surname, First name: \_\_\_\_\_

Street, Number, P.O. Box: \_\_\_\_\_

Postcode, Town: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

### Payment address

**IBAN number:**

If the IBAN number is not known, please provide the following information:

Post office account:

Name of bank:

Clearing no.:

Bank account:

### Details of association membership

Are you already a member of GastroSuisse?

Yes  No

If yes, please provide your membership number:

If no, do you wish to become a member of GastroSuisse?

Yes  No

### Branches

Do you have other branches?

Yes  No

### Employees

Staff since:

Number of employees:

Surname, First name of employee:

Date of birth:

Surname, First name of employee:

Date of birth:

Surname, First name of employee:

Date of birth:

Surname, First name of employee:

Date of birth:

Surname, First name of employee:

Date of birth:

Surname, First name of employee:

Date of birth:

Surname, First name of employee:

Date of birth:

Surname, First name of employee:

Date of birth:

Surname, First name of employee:

Date of birth:

Surname, First name of employee:

Date of birth:

Surname, First name of employee:

Date of birth:

Surname, First name of employee:

Date of birth:

Does any of the persons to be insured draw benefits from the disability, military or accident insurance or a pension fund or have applications been submitted?  Yes  No

If you have a seasonal establishment, please enter the relevant periods:

Summer season (from – to): \_\_\_\_\_

Winter season (from – to): \_\_\_\_\_

Are you already registered with an AHV compensation office?  Yes  No

If yes, please provide the name of the compensation office: \_\_\_\_\_

Are you affiliated with a pension fund (PF) for your employees?  Yes  No

If yes, please enclose a copy of the confirmation of termination of the relationship with the current pension fund.

#### Enclosures to be submitted

- Copy of the confirmation of termination of the relationship with the current pension fund (if there is a change of pension fund)
- Copy of Commercial Register excerpt
- Affiliation agreement with GastroSocial

Comments:

#### General

- If the obligation to notify is violated or false information is provided, the GastroSocial Pension Fund can withdraw from the insurance.
- The GastroSocial Pension Fund reserves the right to review enrolment at the regulatory conditions on the basis of a medical examination report.
- The GastroSocial Pension Fund reserves the right to refuse the conclusion of an insurance contract.

I herewith confirm that I have answered all the questions in this registration form truthfully and completely and that I have taken note of the information provided under «General».

**Place and date**

**Stamp and legally valid signature**

**Incomplete documentation will delay the application process.**

Please sign and send to GastroSocial.