

Affiliation agreement Scala Management

between the specified employer and the GastroSocial Pension Fund on behalf of the company specified below

Employer: _____ **Company no. (UID):**
C H E -

Legal entities according to entry in commercial register (public limited company, Ltd, cooperative, foundation, association, share commandite company, public sector entity, e.g. Sample plc., Restaurant Ltd etc.), sole trader (sole proprietorship) or partnership entered or not entered in commercial register (simple partnership, general partnership, limited partnership, community of heirs, e.g. Sample & Co., Example + Sample, Sample + Partner etc.)

Group of insured persons: _____ **Settlement number:**
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(e.g. executive management, executive board, department heads)

Street, Number: _____ Postcode, Town: _____

Telephone: _____ E-Mail: _____

1 Did the persons to be insured experience any incapacity for work in the period between the company affiliation date and the signing of this affiliation agreement? Yes No

2 The employer applies for affiliation of the above-mentioned group of persons with the GastroSocial Pension Fund from:
Day Month Year

Preferred pension plan:

Scala Basis Basic insurance as defines in the BVG

Scala Top Supplementary insurance for higher salaries

Scala Plus Supplementary insurance for higher salaries and benefits

Integral Supplement to the above-mentioned plans: Insurance of the total gross salary subject to social security contributions (AHV), without any coordination deduction

according to the enclosed pension plan

When do you wish to submit the salary notification to the GastroSocial Pension Fund?

- monthly
- quarterly
- annually

If we do not hear from you to the contrary, we will assume that you wish to submit quarterly salary notifications.

3 Persons to be insured:

Please take the information concerning the insured persons from the offer made the (date): _____

According to the enclosed list

According to this list:

Last name, First name: _____ **AHV number:**

Annual gross salary subject to AHV contributions: _____

Last name, First name: _____ **AHV number:**

Annual gross salary subject to AHV contributions: _____

