



# Notification of withdrawal

Contract no. /

**Employer** Name and location

**Insured person**

Last name

First name

Insurance number

Street

Date of birth

Gender

m  f

Postal code and place

Country

Can be reached at

Private email address

Phone no.

**Termination of  
employment  
relationship**

Date of withdrawal (take account of protection against dismissal and termination deadlines as well as the obligation to continue salary payments)

Is the insured person fully fit for work?  
from a health viewpoint?

Yes

No

For persons who are not fully fit for work, kindly submit the "Notification of incapacity for work" form and the relevant attachments to us.

Early retirement?

If yes, contact will be established

Yes

No

Leaving due to headcount  
"reduction/restructuring"?

Yes

The employer is legally obligated to inform the foundation without delay of any reduction in the workforce for economic reasons through downsizing or restructuring of his company (organizational measures leading to the cessation of tasks or the transfer of entire operating units to another company), resulting in non-voluntary departures. For details, see the Regulations on Partial and Total Liquidation of Occupational Benefits Funds.

**Remarks**

**Person submitting  
notification on behalf  
of the employer**

Date

Surname

First name

E-mail address

**Note** We carry out the clarification for the transfer of the withdrawal benefit (vested benefits) directly with the insured person.

**Please send to** formsservice.bvg@axa.ch

or to:

AXA

Postfach 300

8401 Winterthur