Reset

Print

Application

Contract n. ..... / .....

Employer Name and location*

.....

1* Name	First name	2* Date of birth (Day / Month / Year)	3* Gender (Male / Female)	4* Nationality	5* Country of employment	6* Annual salary in CHF	7* Start of insurance / Start of employment (Day / Month / Year)	8 Marital status	9 Other language for the personal certificate	10* Fully able to work (Yes / No)	11 Additional information, if needed (such as category, level of employment for part-time employees, supporting duties, etc.)
			☐ ☐				I ..... E			☐ ☐	
			☐ ☐				I ..... E			☐ ☐	
			☐ ☐				I ..... E			☐ ☐	
			☐ ☐				I ..... E			☐ ☐	

Comments

.....

Insurance coverage
We hereby acknowledge that coverage is contingent on the accuracy of the adjacent statement and that the Rofenberg Foundation may withdraw from the policy if information provided proves to be incorrect. See "Details on the application form" for more details on insurance coverage.

Ability to work
We will submit the "Supplement to the application" form for persons listed in Column 10 who are not fully fit for work (Please refer to "Details on the application form" for a definition of "ability to work.")
We confirm that the persons for whom "yes" is checked are fully fit for work at the start of insurance coverage.

Column 4 and 5
Please include country code

Column 7
I = Start of insurance (only complete if different from start of employment)
E = Start of employment

Column 8
Marital status:
1 = single
2 = married
3 = widowed
4 = divorced

Column 9
Other language for personal certificate
1 = German
2 = French
3 = Italian

Person submitting notification on behalf of the employer

Date ..... Surname ..... First name .....

E-mail address .....

* Mandatory

Details on the application form

Ability to work

A person is not considered to be fully fit for work if, at the beginning of the insurance, he/she

- must be absent from work, partly or fully, for reasons of health,
- receives daily allowances due to sickness or accident,
- has filed a claim with a federal disability insurance,
- receives a pension for full or partial disability,
- can no longer be employed in a manner suitable to his/her education or abilities for reasons of health.

All other persons are considered to be fully fit for work.

The form ”Supplement to the application”

The form ”Supplement to the application” is to be submitted for all persons who are not fully fit for work in accordance with the above definition.

A ”Supplement to the application” must also be submitted for those persons whose initial or, in case of changes, additional benefits to be insured exceed certain limits. We will notify you about these persons accordingly. The inclusion in the insurance may depend on the results of a physical examination or information provided by a doctor. We bear the corresponding costs.

Insurance coverage

Insurance coverage is **definite and without restriction** for all persons who require no ”Supplement to the application”.

Insurance coverage remains **provisional** for the time being for the other persons. We will inform you in writing whether the insurance coverage granted is normal or with restriction. Upon receipt of this notification, insurance coverage becomes definite.

CRS-I form for self-certification of an individual's tax residence»

The "Rofenberg" Employee Welfare Foundation is subject to the automatic exchange of information (AEOI). All insured persons including the status of their retirement assets and their benefit payouts will be reported to the Principality of Liechtenstein Tax Administration.

Every insured person is obligated to complete AXA Life Ltd.'s CRS-I form on their enrollment and withdrawal. Any future changes in relation to new deployments/country of residence and associated new tax residence must be reported without delay using the CRS-I form to AXA Life Ltd.

CRS - I

Contract no. _____

Individual tax residence self-certification FORM *(please complete parts 1-3)*
Before you complete the form below, please read the instructions starting on page 3.

Part 1: Identification of an individual account holder

A. Name of account holder *(insured person / entitled person)*:

Last name(s): _____

First name(s): _____

B. Current residential address

Street, house no.: _____

Country: _____

Postal code/place: _____

C. Postal address: *(Please only complete if different to the address in Section **B** above)*

Street, house no.: _____

Country: _____

Postal code/place: _____

D. Date of birth*(DD/MM/YYYY)* _____

E. Place of birth

Town or city _____

Country _____

Nationality _____

Part 2: Country of residence for tax purposes

Please complete the following table stating where the account holder is resident for tax purposes and, for each country indicated, the account holder's Tax Identification Number (TIN) or equivalent number.

	Country of residence for tax purposes	Tax Identification Number (TIN)	If no TIN is available, please enter the reason *A, B, or C**
1			
2			
3			

*If no TIN is available, please state the appropriate reason A, B or C as defined below:

Reason A: *The country in which the account holder is liable to pay tax does not issue TINs to its residents.*

Reason B: *The account holder is unable to obtain a TIN or equivalent number for another reason. (If you have selected this reason, please explain why you are unable to obtain a TIN in the table below).*

Reason C: *No TIN is required. (Note: Only select this reason if the authorities of the country of tax residence entered above do not require the TIN to be disclosed.)*

If you selected ***Reason B*** above, please explain in the following boxes why you are unable to obtain a TIN.

1	
2	
3	

Part 3: Declarations and signature

I confirm that all statements made in this declaration are, to the best of my knowledge and belief, correct and complete.

I undertake to advise **AXA Life Ltd.** within **30** days of any change in circumstances that could affect the status of the tax residence of the person identified in Part 1 of this form or cause the information contained herein to become inaccurate, and to provide **AXA Life Ltd.** with a suitably updated self-certification and declaration within **30** days of such change in circumstances.

Signature: _____

Name in block capitals: _____

Date: _____

Note: If you are not the account holder, please state in what capacity you are signing the form. If you are signing under a power of attorney, please include a certified copy of the power of attorney.

Function: _____

INSTRUCTIONS

Parts 1-2:

The **"Rofenberg" Employee Welfare Foundation** is obligated, in accordance with the **provisions under the framework of the Common Reporting Standard (CRS) of the OECD as well as the legal bases in the Principality of Liechtenstein on the international automatic exchange of information in tax matters (AEOI law)**, to record and report certain information about the tax residence of an account holder and to observe these commitments through AXA Life Ltd. as founder. Each jurisdiction has its own rules for determining tax residence. As a rule, your tax residence and the country you live in are the same. However, under special circumstances (e.g. studying abroad, working abroad, or extended travel), you may be resident in another country or in more than one country at the same time (dual residence). It is likely that the country (countries) in which you pay income tax is/are also the country (countries) of your tax residence. For more information about your tax residence, please contact your tax advisor or follow this link: AEOI portal of the OECD.

If your tax residence (or the tax residence of the account holder if you are completing this form on their behalf) is located **outside of the Principality of Liechtenstein**, we may be required by law to pass on the information on this form, as well as other financial information relating to your financial accounts, to **the Principality of Liechtenstein Tax Administration**.

You will find definitions as to who is classified as an account holder, as well as other terms, in the Appendix.

This form retains its validity as long as there are no changes in the circumstances affecting the tax status of the account holder or other mandatory fields on this form. In the event of a change of circumstances that cause this form to become inaccurate or incomplete, you are required to inform us and to send us an updated self-certification.

This form serves only to collect information that it is not prohibited to collect under local laws.

If you are a US person according to the provisions of the US Internal Revenue Service (IRS), you may also have to complete the IRS W-9 form.

If you are completing this form on behalf of another person, please let us know in Part 3 in which capacity you are signing. For example, you might be the custodian or nominee of an account of the account holder, or you might be completing the form under a power of attorney.

As a financial institution, we are not allowed to give tax advice.

If you have any questions about this form, these instructions or determining your tax resident status, please do not hesitate to contact your tax advisor or the tax authorities in your country.

More information, including a list of jurisdictions that have signed the agreement on the automatic exchange of information, as well as more details on the information required, can be found on the OECD portal on the automatic exchange of information.

Part 3

I agree that the information contained in this form about the account holder and about the reportable account (reportable accounts) may be reported to the tax authorities of the country in which the account (accounts) is (are) maintained and may be shared with the tax authorities of another country or other countries in which the account holder may be tax resident in accordance with the intergovernmental agreement on the exchange of account information.

With my signature, I certify that I am the account holder of the account (all the accounts) to which this form relates (or am authorized to sign for the account holder in relation to all accounts to which this form relates).

Appendix: Definitions

Note: The following definitions are intended to help you complete this form. Further details can be found in the OECD Common Reporting Standard for the Automatic Exchange of Financial Account Information (CRS), the associated commentary to the CRS, and domestic guidance. This can be found at the following link: OECD.

If you have any questions, please do not hesitate to contact your tax advisor or the tax authorities in your country.

Account Holder
The account holder is the person who is insured with the "Rofenberg" Employee Welfare Foundation through their employer. The account holder is also referred to as the insured person. An individual retirement account/vested benefits account is maintained as a reportable account for this person. In a benefit case, each eligible person is regarded as the account holder.

Financial Account
A financial account is an account that is maintained by a financial institution. This includes: deposit accounts, custody accounts, equity and debt capital participations in certain investment companies, redeemable insurance contracts, and pension insurance contracts.

Participating Jurisdiction
The term "Participating Jurisdiction" refers to a jurisdiction with which an agreement exists to provide the information referred to in the Common Reporting Standard for the Automatic Exchange of Financial Account Information (CRS).

Reportable Account
The term "Reportable Account" refers to an account held by one or more reportable persons or by a passive non-financial entity ("NFE") with one or more controlling persons who are reportable persons.

Reportable Jurisdiction
A Reportable Jurisdiction is a jurisdiction with which an obligation to provide financial account information is in place.

Reportable Person
A Reportable Person is a person who is tax resident in a Reportable Jurisdiction under the tax laws of that jurisdiction. Persons with dual residence may rely on the tiebreaker rules in tax conventions (where applicable) in order to determine their residence for tax purposes.

TIN (including "functional equivalent")
The term "TIN" refers to the Tax Identification Number or a functional equivalent in the absence of a TIN. A TIN is a unique combination of letters or numbers assigned by a jurisdiction to a natural person or a legal entity and used to identify the natural person or legal entity for the purposes of administering the tax laws of such jurisdiction. Further details about recognized TINs can be found under the following link: OECD portal.

Some jurisdictions do not issue a TIN. However, these jurisdictions often use a different number with a high degree of data security providing an equivalent level of identification (a "functional equivalent"). Examples of these types of number for persons include a social insurance or insurance number, a citizen or personal identification number, a benefit code, a benefit number, and a resident's registration number.

Reset

This form will be scanned electronically.
Please write legibly.

Supplement to the application

Contract no. /

Employer
Name and location

Insured person
Name | First name | Nationality

Street, postal code and location | Date of birth | Gender ☐ m ☐ f

Occupational activities | Country of employment

Can be reached at
Private email address | Phone no.

Height (cm) | Weight (kg)

Health questions
These pertain to the **last 5 years** before insurance coverage began or before the benefit increase. Please also provide the details as requested for the questions you answered with «Yes».

Details

1. Were you fully or partially incapacitated at the beginning of the insurance or at the time when benefits increased? ☐ Yes ☐ No

Has a decision be reached on disability insurance (IV)? ☐ Yes ☐ No
Please include a copy of the IV decision if you have one. Otherwise, please include statements from the daily sickness benefits or accident insurance provider, if available.

2. Do you have any health impairment or damage as the result of an accident or illness? ☐ Yes ☐ No

Which | Since when | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address)

3. Do you have or have you had one or several of the following health disorders or impairments: Arthritis, asthma, disease of the eye, bronchitis, high blood pressure, high cholesterol, heart disease, cancer, paralysis, multiple sclerosis, impaired sight or hearing that has **not** been corrected, psychological disorders or impairments, rheumatism, thyroid or glandular disorders, stroke, spine disorders, diabetes or illnesses, symptoms or disorders other than those listed here? ☐ Yes ☐ No

Which | From when to when | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address) administering treatment

Which | From when to when | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address) administering treatment

Which | From when to when | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address) administering treatment

*** 1 = healed/all is well/treatment completed**
*** 2 = not healed/all is not well/still in treatment or under observation**

4. Did you miss work as a result of an accident or illness partially or fully for more than two weeks? ☐ Yes ☐ No

Why | From when to when | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address)

Why | From when to when | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address)

5. Were you ever in the care of a physician, chiropractor or psychologist for more than 4 weeks, or do you require, take, or did you take, any medication, painkillers, sleeping pills, sedatives, or drugs regularly? ☐ Yes ☐ No

Why do you or did you require treatment/were you under observation | From when to when | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address)

What medication, etc. | From when to when | How much per week

Why do you or did you require treatment/were you under observation | From when to when | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address)

What medication, etc. | From when to when | How much per week

6. Did you undergo any special medical examinations, such as check-ups, x-rays, ECG, HIV test, etc., **that produced not a normal result** (do not include results from genetic tests)? ☐ Yes ☐ No

Which | When | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address)

Which | When | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address)

7. Have you had an operation (inpatient or outpatient), or is an operation planned or has one been recommended? ☐ Yes ☐ No

Which | When | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address)

Which | When | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address)

8. Which doctor (also chiropractor, psychotherapist) is best able to offer information about your state of health?

Name | First name | Postcode and location

*** 1 = healed/all is well/treatment completed**

*** 2 = not healed/all is not well/still in treatment or under observation**

Additional information
for job changes

Were you insured under an occupational benefits plan with your previous employer? ☐ Yes ☐ No
If so, please provide us with the following information

Company or occupational benefits institution | Street, postcode and location

Is a health proviso currently in place from your previous pension fund? ☐ Yes ☐ No
(If yes, please include a copy)

Remarks

Declaration

I hereby authorize doctors, psychotherapists, physiotherapists, chiropractors, hospitals, accident and daily benefits insurers, and my previous occupational benefits institution to provide the medical services of AXA Life Ltd with information about my state of health and/or about my previous insurance coverage in connection with this insurance.

I am aware that this coverage depends on the accuracy of this declaration and that the foundation can withdraw from the contract under the statutory provisions if information contained herein proves incorrect.

Tax liability

The insured person hereby confirms accepting sole responsibility for notifying the relevant tax authorities and for meeting all tax liabilities that result from payments received.

Signature

Date | Signature

Please send to

AXA Life Ltd
P.O. Box 300
8401 Winterthur