

## Application for family allowances for employed persons

Canton



Company:

Customer ID

### 1 Applicant

Last name		First name		Social security no. 756.
Date of birth	Gender <input type="checkbox"/> male <input type="checkbox"/> female	Nationality		Asylum seeker <input type="checkbox"/> yes <input type="checkbox"/> no
Civil status <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> separated <input type="checkbox"/> divorced <input type="checkbox"/> widowed <input type="checkbox"/> registered partnership <input type="checkbox"/> partnership dissolved				Since (date)
Address: Street / no.		Zip / City	To be contacted at (phone, e-mail)	
From when do you apply to receive an allowance (date)?		Are you currently receiving daily benefits from any insurance (IV, ALV, UVG, KTG, MSE *.) <input type="checkbox"/> yes <input type="checkbox"/> no If yes, specify type of benefit and paying institution:		

### 2 Employer

Company			Customer ID 15.
Employed since / to	Hours of work per month	Place of work (canton)	Applicant's expected OASI annual salary
Address: Street / no.		Zip / City	To be contacted at (phone, e-mail)
Further employers: name, address, to be contacted at (phone, e-mail), contact person			

### 3 Other parent

If the current partner is not the other parent, please fill in the corresponding supplement sheet!

Last name		First name		Social security no. 756.	
Date of birth	Gender <input type="checkbox"/> male <input type="checkbox"/> female	Nationality		Since (date)	
Civil status <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> separated <input type="checkbox"/> divorced <input type="checkbox"/> widowed <input type="checkbox"/> registered partnership <input type="checkbox"/> partnership dissolved					
Address: Street / no.		Zip / City	To be contacted at (phone, e-mail)		
Are you receiving daily benefits from any insurance (IV, ALV, UVG, KTG, MSE *)? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, specify type of benefit and paying institution:					
Is there an employment relationship? If yes: name, address and phone no. of the employer		<input type="checkbox"/> yes <input type="checkbox"/> no	Since (date)	Place of work (canton)	Does the salary exceed the applicant's salary? <input type="checkbox"/> yes <input type="checkbox"/> no
Is this person registered in a social security compensation office as being self-employed (SE) or non-employed (NE)? <input type="checkbox"/> SE <input type="checkbox"/> NE If yes, at which social security compensation office?					
Date and signature other parent					



## 4 Child(ren) up to the age of 25

If you wish to register more than 5 children, please fill in an additional application.

### General information about the child

Last name / First name ----- Social security no.	Date of birth ----- Gender (m/f)	Address of domicile ----- Zip / City	Net income **	Relationship between child and applicant						Disability yes***
				B*	A*	S*	F*	S*	G*	
756.			CHF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
756.			CHF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
756.			CHF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
756.			CHF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
756.			CHF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* B = biological child, A = adopted child, S = stepchild, F = foster child, S = siblings, G = grandchild

\*\* Net income (salary, pension, daily benefits, yield on assets)

\*\*\* Children who are unable to work because of an illness or disability

## 5 Additional information

(Does or did) any other person draw an allowance for one or several of the children listed in chapter 4 above?  yes  no

If yes: Please enclose the confirmation of the pertinent social security compensation office/family allowance office

## 6 Documents to be enclosed

Documents that are not written in one of Switzerland's official languages **must** be translated by a recognised translator.

All applicants:	<ul style="list-style-type: none"> <li>- Copy of the family booklet (parents and children) or copies of the children's birth certificates and marriage certificate</li> <li>- Confirmation of pertinent alternative provider (IV, ALV, UVG, KTG, MSE), if any benefits were received by any of the persons concerned</li> <li>- Copy of the latest family allowance decision or family allowance confirmation by the latest employer, including specific date of expiry.</li> </ul>
Foreigners:	<ul style="list-style-type: none"> <li>- Parents: valid foreigner's ID and marriage certificate</li> <li>- Children: valid foreigner's ID</li> </ul>
Divorced or separated persons:	<ul style="list-style-type: none"> <li>- Excerpt from the divorce decree or decree of judicial separation regarding custody and care</li> </ul>
Unmarried Person:	<ul style="list-style-type: none"> <li>- Acknowledgement of paternity</li> <li>- Support contract</li> <li>- Child support agreement about joint custody</li> </ul>
For children over 16 years to 25 years of age:	<ul style="list-style-type: none"> <li>- Current confirmation of education / medical certificate for occupational disability</li> <li>- Apprenticeship contract - school confirmation - trainee agreement – confirmation of studies</li> </ul>
Children with residence abroad:	<ul style="list-style-type: none"> <li>- Current confirmation by the pertinent foreign authorities on family allowances or a completed E411 form</li> </ul>
<b>Date and signature (applicant)</b>	<b>Date, stamp and signature (employer)</b>

Please make sure to comply with the requirements on the next page.

## 7 Important notes / confirmation of application

### Important notes

- Applications can only be processed if fully completed and accompanied by all pertinent documents/enclosures.
- Employers act at their own risk if paying family allowance prior to having received the corresponding allowance decision.

### The undersigned persons confirm that

- they have completed the application truthfully,
- they have taken note that only one full allowance can be drawn for each child,
- they are liable to prosecution if providing false information or failing to disclose,
- they must pay back any allowance claimed wrongfully,
- they immediately notify their employer, or the compensation office, respectively, of any changes in their family situation that might have an impact on their entitlement to child allowance.

Please submit the completed application form to your employer's HR administration. They will check completeness and transmit the application to the competent family compensation fund.

If you want to send the application yourself, please submit it first to your HR administration so they can complete point 2 of the application.

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## Supplement sheet to the "Application for family allowances for employed persons"

### Information on current partner

Last name		First name		Social security no. 756.
Date of birth	Gender <input type="checkbox"/> male <input type="checkbox"/> female		Nationality	
Civil status <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> separated <input type="checkbox"/> divorced <input type="checkbox"/> widowed				since (date)
<input type="checkbox"/> registered partnership		<input type="checkbox"/> partnership dissolved		
Address: Street /no.		Zip / City	To be contacted at (phone, e-mail)	
Are you currently receiving daily benefits from any insurance (disability, unemployment, accident, sickness, maternity etc.) <input type="checkbox"/> yes <input type="checkbox"/> no				
If yes, specify type of benefit and paying institution:				
Is there an employment relationship? <input type="checkbox"/> yes <input type="checkbox"/> no If yes: name, address and phone no. of the employer			Place of work (canton)	Does the salary exceed the applicant's salary? <input type="checkbox"/> yes <input type="checkbox"/> no
Is this person registered in a social security compensation office as being self-employed (SE) or non-employed (NE)? <input type="checkbox"/> SE <input type="checkbox"/> NE If yes, at which social security compensation office?				
<b>Date and signature current partner</b>				

### Abbreviations

IV	Disability insurance
ALV	Unemployment insurance
UVG	Accident insurance
KTG	Health insurance (per diem indemnity)
MSE	Maternity benefit
OASI	Swiss Old Age and Survivors Insurance