

# Notification of Incapacity to Work

\*Contract no.: \_\_\_\_\_

\*Policy no.: \_\_\_\_\_

\*Company: \_\_\_\_\_

Street, no.: \_\_\_\_\_

Please fill out all pages and sign.

Zipcode, city: \_\_\_\_\_

**Illness**

**Accident**

## 1 Personal details concerning the insured person (to be completed by the employer)

\*Last name: \_\_\_\_\_ \*First name: \_\_\_\_\_ \*Date of birth: \_\_\_\_\_

\*Street, no.: \_\_\_\_\_ \*Zipcode, city: \_\_\_\_\_

\*Nationality: \_\_\_\_\_ \*Profession/function: \_\_\_\_\_ \*Civil status: \_\_\_\_\_

\*Commencement of service: \_\_\_\_\_ Tel. no. (home): \_\_\_\_\_ Tel. no. (work): \_\_\_\_\_

\*What was the salary of the insured person upon the incapacity to work? Annual salary (projected, if need be): \_\_\_\_\_

\*Has the employment relationship between the insured person and the employer been terminated?  Yes  No

If yes, what is the date on which employment will end? \_\_\_\_\_

If not, is a termination of employment planned and per which date? \_\_\_\_\_

## 2 Insurance institutions involved in this case

Accident insurer	Accident no.	Insurer for loss of earnings
_____	_____	_____

\*Federal Disability Insurance:

Has the case been reported for early detection?  Yes  No

Has the notification been placed by the insured person?  Yes  No

Notification foreseen? Competent canton \_\_\_\_\_  Yes  No

\*Military Insurance  Yes  No

Other insurance carriers (including foreign social insurance institutions):

## 3 With respect to persons required to support others

(\*) Information concerning children for whom the benefits are being claimed

Last name:	First name:	Date of birth:
_____	_____	_____
_____	_____	_____
_____	_____	_____

### Required Documents:

Copy of the family register and in addition, for children who are Stamp, signature of the employer engaged in an education and who are older than the age limit defined in the regulations respectively the insurance contract, a confirmation of the relevant educational institution.

\_\_\_\_\_  
Place, date

\_\_\_\_\_  
Stamp, signature of the company

---

#### 4 Information concerning the incapacity to work

First notification                       Relapse

\*Has the case been reported to the AI office for early detection?                       Yes                       No

In the event of **illness**

a) (\*) What are you suffering from?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

b) (\*) When did the disorder begin?

\_\_\_\_\_

\_\_\_\_\_

c) (\*) Have you ever been treated for the same illness?                       Yes                       No

(\*) If so, when? \_\_\_\_\_

(\*) By which doctor? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In the event of **accident** (including occupational illnesses)

a) (\*) Time and place of the accident?

\_\_\_\_\_

\_\_\_\_\_

b) (\*) How did the accident occur? (incl. involved persons, items, vehicles)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(\*) Is there a liable third person?                       Yes                       No

(\*) Has a police report been made?                       Yes                       No

c) (\*) Type of injuries?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please enclose **documents** (decisions, degrees, confirmations) of the accident insurer(s).

---

#### 5 Medical Treatment

a) \* When did you visit a doctor for the first time? \_\_\_\_\_

\*Which doctor? \_\_\_\_\_

b) (\*) Doctors who were subsequently consulted? When and who?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

c) \*Name and address of the doctor who is currently treating you or monitoring your health.

\_\_\_\_\_

---

#### 6 During which period and to what degree were you incapable of working?

*Period from	*until	*degree of incapacity to work in %
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

---

**7 Authority****a) Other insurers**

For the purpose of verifying the insured's claim and entitlement to benefits, the undersigned hereby explicitly authorizes Helvetia to obtain the required information from, and in particular to inspect the relevant records (e.g. medical reports and reports by other institutions such as the occupational guidance service) of, all public and private insurance carriers, including the medical fund, health insurer, daily benefits insurer, disability insurer, AI offices, pension funds, etc. involved in this benefit case.

**b) Doctors and other providers of medical services**

The signature below also provides Helvetia with authorization to obtain the information it believes to be essential from doctors and other providers of medical

services such as hospitals, sanatoriums, etc. The doctors and other institutions mentioned above are therefore unconditionally released from their obligation of medical secrecy towards Helvetia.

**c) Forwarding of own records**

The undersigned also authorizes Helvetia to send documents pertaining to the disability history, in particular medical documents, to the designated AI office for the purpose of increasing the insured's chances of occupational rehabilitation. However, this procedure does not replace the registration with the AI, which must be done by the insured themselves.

Last name and first name of the insured person

Date of birth

Social security Number (OASI)

\_\_\_\_\_

By their signature the undersigned grants the above power of attorney in full (a–c).

Place, date

Signature of the insured person or the legally appointed representative

Enclosures

---

**Please return this form to:**

Helvetia Swiss Life Insurance Company Ltd, P.O. Box 3855, 4002 Basle