Swisscanto
Collective Foundations of the Cantonal Banks

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Swisscanto
Stiftungen/Fondations/Fondazioni

Notification of Incapacity to Work or Earning Disability

Part 1: Employer

On behalf of Helvetia Swiss Life Insurance Company Ltd (hereafter called Helvetia) as the insurance provider of the Swisscanto Collective Foundations

Contracting office:

*Contract no.: *Policy no.:

*Company:

Street, no.:

Zipcode, city:

Notes:

- **Part 1** is to be completed **by the employer** and may be submitted separately from Part 2.
- **Part 2** is to be completed **by the insured person** and may be submitted separately from Part 1.

1 Personal details concerning the insured person

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

*Street, no.: *Zipcode, city:

*Profession/function: *Civil status:

*Commencement of service: Tel. no. (work):

*Salary of the insured person upon the incapacity to work or earning disability?
Annual salary (projected, if need be):

*Degree of occupation of the insured person prior to the incapacity to work in percent

*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 dissolution of employment planned and per which date?

*Commencement of incapacity to work:

☐ **Illness** ☐ **Accident**

2 Insurance institutions involved in this case

Daily sickness benefits insurance provider Accident insurer Accident no.

*Federal Disability Insurance:

Has the case been reported for early detection? ☐ Yes ☐ No

Has the notification been placed? ☐ Yes ☐ No

Competent canton

*Military Insurance ☐ Yes ☐ No

Other insurance carriers (including foreign social insurance institutions):

Place, date Stamp, signature of the company

* mandatory fields must be completed

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Notification of Incapacity to Work or Earning Disability

Part 2: Insured person

Please sign on page 2.

On behalf of Helvetia Swiss Life Insurance Company Ltd (hereafter called Helvetia) as the insurance provider of the Swisscanto Collective Foundations

*Contract no.: *Policy no.:

*Company:

*Last name:

*First name:

*Date of birth:

Tel. no. (home):

1 Information concerning the incapacity to work or earning disability

☐ **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).

2 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.

* mandatory fields must be completed

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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.

4 Authority

Pursuant to the regulations of the employee benefit institution or the autonomous/semi-autonomous foundation of the undersigned, Helvetia Swiss Life Insurance Company Ltd (hereinafter referred to as “Helvetia”) is responsible for managing the employee benefit institution or is responsible for the administration and settlement of claims of the autonomous/semi-autonomous foundation.
The undersigned therefore authorises Helvetia, in its function as manager of the employee benefit institution or as the entity entrusted with the administration and settlement of claims on behalf of the autonomous/semi-autonomous foundation, to process the data required for the clarification of his/her entitlement to benefits and settlement of the claim filed.

Furthermore, the undersigned authorises Helvetia to assess any entitlements to benefits of the undersigned towards Helvetia with regard to Federal Law on Insurance Contracts on the basis of data obtained and if necessary to coordinate claims of the employee benefit institution and Helvetia.

Through this power of attorney, Helvetia is also expressly authorised to obtain relevant information and data as well as to inspect and take receive relevant records (of a medical, professional, financial and legal nature, such as medical reports and reports of vocational guidance) from all public- and private-sector insurance institutions (insurance companies and insurance institutions such as Swiss Federal Disability Insurance, Swiss Federal Accident Insurance, Swiss Federal Military Insurance, accident and health insurance companies, daily allowance insurers, co-insurers or reinsurers, employee benefit institutions, etc.) involved in these claims, as well as from the treating physicians, other healthcare providers, hospitals, medical institutions, employers, government agencies and authorities, such as residents' registration offices and investigative authorities, debt enforcement offices, tax authorities, etc. (hereinafter “**third parties**”).

The undersigned authorises these third parties to give Helvetia or its medical service, upon request, the data required to clarify and process the claim and to transmit all relevant records and expressly releases these third parties from their legal and contractual duty of discretion/obligation of secrecy. The third parties authorised to disclose information are authorised to transmit all data and records relevant to the settlement of the filed claim to Helvetia even without submission of a new request.

Finally, the undersigned authorises Helvetia to transmit all data relevant to the settlement of the filed claim to the third parties involved in Switzerland and abroad.

In the event of failure to provide the present power of attorney, Helvetia will not be able to make the necessary inquiries, which may result in insufficient clarification of the scope of the earning disability and therefore lead to the rejection of the insurance benefits. The authorisation of the undersigned is independent of any obligation to pay benefits on the part of his/her employee benefit institution.

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

By their signature the undersigned grants the above power of attorney in full.

Place, date	Signature of the insured person or the legally appointed representative

Enclosures

Please return this form to: Your contracting office or Swisscanto Collective Foundation, Branch office, St. Alban-Anlage 26, P.O.Box 3855, 4002 Basle

* mandatory fields must be completed