



Notification of Incapacity to Work

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

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: _____

*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 _____

* mandatory fields must be completed



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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: _____

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

a) (*) What are you suffering from? a) (*) Time and place of the accident?

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

b) (*) When did the disorder begin?

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

(*) If so, when?

(*) By which doctor?

(*) 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.

