Helsana Unfall AG
Kundenservice Unternehmen
Postfach, 8081 Zürich www.helsana.ch EAN 7601003005431

Helsana

Minor accident report UVG

Claim number

1. Employer	Name and address with postcode	Phone no.	Policy-No. UVG
		E-Mail	Policy-No. UVG-additional
		Normal place of work of insured person (branch of company)	
2. Insured person	Surname and first name	Date of birth	AHV number
	Street	Phone no	Nationality/Residence permit
	Country Postcode Place	E-Mail	Marital status
3. Employment	Date of employment	Normal occupation	
	Position: ☐ Upper Management ☐ Middle Management ☐ Employee ☐ Apprentice ☐ Trainee		
	Employment contract: ☐ Unlimited empl. contract ☐ Limited empl. contract ☐ Terminated empl. contract as of:		
	Insured person's working hours: (hours/week) Contractual operating level: Percent		
	Customary company working hours: (hours/week) Employment: ☐ Irregular ☐ Short-time working ☐ Intermediate earnings		
4. Date of accident	Day Month Year Time (hours, minutes)		
5. Place of accident	Place (name or postcode) and location (e.g. workshop, street)		
6. Description of the accident (Suspicion of occupational illness)	Activity at the time of the accident; events leading to the accident, objects, vehicles involved		
	Person(s) involved:		
	Was the accident reported to the police? ☐ Yes If yes, drawn up by: ☐ No ☐ Not known		
	Is there an accident form? ☐ Yes If yes, please attach a copy. ☐ No		
7. Occupational accident	Objects involved (e.g. machines, tools, vehicles, materials; exact description please)		
8. Non-occup. accident	When did the injured person **last** work in the company **prior to the accident** (day, date, time)?		
	until: Reason for absence:		
9. Injury	Part of body affected: ☐ left ☐ right ☐ not specific		
	Nature of the injury:		
10. Doctors' addresses	Doctor or hospital/clinic providing initial treatment	Subsequent doctor or hospital/clinic providing treatment	
11. Special cases	Other employer: ☐ No ☐ Yes, Name and adress: ☐ Withholding tax liability		
	☐ Voluntary insurance (employer/self¬employed) ☐ Family member, shareholder ☐ Employee working abroad		
	Name of compulsory healthcare insurance (incl. policy no.):		

Place and date **Signature of the injured person** **Stamp and signature of the employer**

Information for the employer

This minor accident report must be completed if the injury does not result in **any incapacity to work** or if the incapacity to work does not exceed a **maximum of 3 calendar days** (date of the accident and the 2 following days).

Exceptions: Instead of this minor accident report, a set of forms «Accident report UVG» must be completed in the event of
- occupational illness,
- dental injury or
- relapse

If any other doctor(s) are consulted we will send him/them an invoice form.
For reimbursement claims of bills, which have already been paid, please include documents and then the payment location (post/bank account).

Distribution: Helsana

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