

Sickness and accident notification for insured persons with individual daily allowance insurance

incl. persons on fixed payroll insured under the group policy

Contract no.	_____
Insured person no.	_____

1. Insured person	Surname, first name, address, incl. postcode _____ _____	Date of birth _____	AHV number (13 digits) _____
	<input type="checkbox"/> male <input type="checkbox"/> female	Nationality _____	Telephone _____
2. Activity	Prevailing professional activity Vocation learnt _____	Date of employment _____	
	Employment contract terminated as of time-limited until _____	<input type="checkbox"/> Employed	<input type="checkbox"/> Unemployed
3. Incapacity to work	From date _____	<input type="checkbox"/> Sickness	<input type="checkbox"/> Accident
	Until date _____	<input type="checkbox"/> Maternity, expected date of birth _____	
4. Attending physician/ hospital	Expected duration _____		
	Name and address, including postcode _____ _____		
5. Payment details	Name of accountholder _____	Name and address of bank _____	
	Postal account no. _____	Bank account no. _____	
	IBAN no. _____	Bank clearing no. _____	
	Payment to (only insured persons in group policy) <input type="checkbox"/> Insured person <input type="checkbox"/> Employer		
6. Other insurance benefits	Are you /is the insured person already entitled to daily allowance or retirement pension by means of: health insurance, SUVA or compulsory accident insurance, disability insurance, old-age and survivors' insur- ance, military insurance, unemployment insurance, private insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes		
	If yes, policy no. _____ Name of company _____		
7. Occupational pension plan	Name of occupational pension plan insurer _____		
8. Disability insurance	Notification for early registration filed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, when _____
	IV decision filed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, when _____
9. Proof of loss of income	Please fill out the next page.		

Self-employed persons and company owners on fixed payroll	Sector	Legal form	Number of employees
	In the event of incapacity to work, does the business have to be closed?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If not, does your incapacity to work cause additional costs or losses of turnover?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, why?		
			CHF /month
		CHF /month	
Please enclose a copy of the profit and loss statement of the last accounting year.			

Unemployed persons	Please enclose a copy of the last unemployment insurance statement.
---------------------------	--

Employed persons	Please fill out the next page (or have it filled out by your employer) and have it signed by your employer.
-------------------------	--

Place and date

Signature of insured person

Sickness and accident notification for insured persons with individual daily allowance insurance

incl. persons on fixed payroll insured under the group policy

Contract no.	_____
Insured person no.	_____

Insured person	Surname, first name, address, incl. postcode	Date of birth	AHV number (13 digits)
	_____	_____	_____
	_____	Nationality	Telephone
	_____	_____	_____
	<input type="checkbox"/> male <input type="checkbox"/> female	Language	_____

Employed persons Incl. family members working on fixed payroll			%	CHF/hour	CHF/day	CHF/month	CHF/year
	Basic salary (gross)	_____	_____	_____	_____	_____	_____
	Cost of living bonus	_____	_____	_____	_____	_____	_____
	Piecework / commission	_____	_____	_____	_____	_____	_____
	Child benefits / family allowance	_____	_____	_____	_____	_____	_____
	Compensation for paid leave	_____	_____	_____	_____	_____	_____
	Compensation for public holidays	_____	_____	_____	_____	_____	_____
	Ex gratia payment / 13 th month's salary	_____	_____	_____	_____	_____	_____
	Other salary bonuses (type)	_____	_____	_____	_____	_____	_____
	Payment in kind (type)	_____	_____	_____	_____	_____	_____
	Weekly working hours			Level of employment			
	Days	Hours	Normal company working hours	<input type="checkbox"/> regular	<input type="checkbox"/> temporary		
	_____	_____	_____	<input type="checkbox"/> irregular	<input type="checkbox"/> shored hours		
	Income you receive / the employed person receives during the incapacity to work						
	<input type="checkbox"/> Continued payment of salary according to working contract						
from	until	%	CHF				
_____	_____	_____	_____				
from	until	%	CHF				
_____	_____	_____	_____				
<input type="checkbox"/> Benefits from group daily allowance insurance							
from	until	%	CHF				
_____	_____	_____	_____				
Is the income subject to withholding tax?			If yes, CEMIS no. (or enclose copy of permit)				
<input type="checkbox"/> Yes <input type="checkbox"/> No			_____				
Please enclose a copy of the last three payroll accountings.							

Place and date

Stamp and signature of employer
