

LAA/UVG Accident Declaration Form

Claim No. _____

Accident Insurer: <input type="checkbox"/> Groupe Mutuel Assurances GMA SA <input type="checkbox"/> Mutuel Assurances SA				
1. Employer	_____		Phone No.:	Policy No.:
	_____		Usual place of work of the injured person:	Administrative Unit:
2. Injured person	Name and first name: <input type="checkbox"/> M <input type="checkbox"/> W		Date of birth:	Social insurance No.:
	Street: _____		Civil status:	Nationality:
	Postal code: _____		Phone number:	Country of residence:
	City: _____		Email: _____	Children under 18 or, if still in training, under 25 ____ child(ren) <input type="checkbox"/> none
3. Employment	Date of employment: _____		Occupation	<input type="checkbox"/> Family member, associate <input type="checkbox"/> Taxed at source
	Position: <input type="checkbox"/> senior executive <input type="checkbox"/> middle management <input type="checkbox"/> employee/worker <input type="checkbox"/> apprentice <input type="checkbox"/> intern/trainee			
	Employment contract: <input type="checkbox"/> indefinite duration		<input type="checkbox"/> fixed duration > date of end of contract: <input type="checkbox"/> terminated > date of termination:	
	Injured person's working hours: ____ hours per week		Contractual activity rate: ____ %	
Usual working hours in the company: ____ hours per week		Occupation: <input type="checkbox"/> irregular <input type="checkbox"/> partially unemployed		
4. Date of the accident	Day/month/year: _____		time (hrs/mins): _____	
5. Place of the accident	Location (name or postal code) and city (e.g. workshop, office, street): _____			<input type="checkbox"/> In Switzerland <input type="checkbox"/> Abroad
6. Facts (accident description)	What was the injured person doing when the accident happened; description of the accident and of any persons, objects or vehicles involved: _____			
7. Report	Who prepared the report? _____		Names of witnesses?	Were the witnesses heard?
	Is there a police report? <input type="checkbox"/> yes <input type="checkbox"/> no		1. _____ <input type="checkbox"/> yes 2. _____ <input type="checkbox"/> no	
8. Non work accident	When was the last time the injured person was at work at the Company before the accident (day, date, time)? Until: _____ Reason for absence: _____			
9. Injuries	Part of the body injured: _____ <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> undefined		Additional information: _____	
Type of injury: _____				
10. Incapacity for work	Did the person stop work after the accident? <input type="checkbox"/> yes, since _____ at _____ % <input type="checkbox"/> no			
	Is the injured person back at work? <input type="checkbox"/> yes, since _____ at _____ % <input type="checkbox"/> no			
11. Doctors' addresses	First aid given by (doctor, hospital, clinic): _____		Follow-up treatment by (doctor, hospital, clinic): _____	
	_____		_____	
12. Salary			CHF rate per	hour
	Base contractual salary (gross)			month
	Cost of living allowance			year
	Family, child allowances			
	Holiday and public holiday allowance in _____ % or _____			
	Bonus, 13th month salary (and others) in _____ % or _____			
Other additional remuneration (e.g. per task/on commission/in kind/allowance for team work) Designations: _____				
13. Other employers	<input type="checkbox"/> yes, Name/address: _____		Health insurance:	
	<input type="checkbox"/> no		_____	
14. Other social security benefits	Is the insured person entitled to a daily allowance or a pension from a private or social insurance?		CCP or bank account of the injured person:	
	<input type="checkbox"/> If so, from which? _____		_____	
	<input type="checkbox"/> No		_____	

Send to: insurance mentioned above

City and date: _____ Stamp and signature: _____

LAA/UVG Accident Declaration Form
Employer's copy

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	_____		Usual place of work of the injured person:	Administrative Unit:
2. Injured person	Name and first name: <input type="checkbox"/> M <input type="checkbox"/> W		Date of birth:	Social insurance No.:
	Street: _____		Civil status:	Nationality:
	Postal code: _____		Phone number:	Country of residence:
	City: _____		Email: _____	Children under 18 or, if still in training, under 25 ____ child(ren) <input type="checkbox"/> none
3. Employment	Date of employment: _____		Occupation	<input type="checkbox"/> Family member, associate <input type="checkbox"/> Taxed at source
	Position: <input type="checkbox"/> senior executive <input type="checkbox"/> middle management <input type="checkbox"/> employee/worker <input type="checkbox"/> apprentice <input type="checkbox"/> intern/trainee		Employment contract: <input type="checkbox"/> indefinite duration <input type="checkbox"/> fixed duration > date of end of contract: <input type="checkbox"/> terminated > date of termination:	
	Injured person's working hours: ____ hours per week		Contractual activity rate: ____ %	
	Usual working hours in the company: ____ hours per week		Occupation: <input type="checkbox"/> irregular <input type="checkbox"/> partially unemployed	
4. Date of the accident	Day/month/year: _____		time (hrs/mins): _____	
5. Place of the accident	Location (name or postal code) and city (e.g. workshop, office, street): _____			<input type="checkbox"/> In Switzerland <input type="checkbox"/> Abroad
6. Facts (accident description)	What was the injured person doing when the accident happened; description of the accident and of any persons, objects or vehicles involved: _____ _____			
7. Report	Who prepared the report? _____		Names of witnesses?	Were the witnesses heard?
	Is there a police report? <input type="checkbox"/> yes <input type="checkbox"/> no		1. _____ <input type="checkbox"/> yes 2. _____ <input type="checkbox"/> no	
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9. Injuries	Part of the body injured: _____		<input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> undefined	
	Additional information: _____ Type of injury: _____			
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	Is the injured person back at work? <input type="checkbox"/> yes, since _____ at _____ % <input type="checkbox"/> no			
11. Doctors' addresses	First aid given by (doctor, hospital, clinic): _____		Follow-up treatment by (doctor, hospital, clinic): _____	
	_____		_____	
12. Salary			CHF rate per	hour
	Base contractual salary (gross)			month
	Cost of living allowance			year
	Family, child allowances			
	Holiday and public holiday allowance in _____ % or _____			
	Bonus, 13th month salary (and others) in _____ % or _____			
	Other additional remuneration (e.g. per task/on commission/in kind/allowance for team work) Designations: _____			
13. Other employers	<input type="checkbox"/> yes, Name/address: _____ <input type="checkbox"/> no _____		Health insurance:	
14. Other social security benefits	Is the insured person entitled to a daily allowance or a pension from a private or social insurance? <input type="checkbox"/> If so, from which? _____ <input type="checkbox"/> No		CCP or bank account of the injured person:	

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Claim No. _____

Accident Insurer: <input type="checkbox"/> Groupe Mutuel Assurances GMA SA <input type="checkbox"/> Mutuel Assurances SA			
1. Employer	_____	Phone No.:	Policy No.:
	_____	Usual place of work of the injured person:	Administrative Unit:
2. Injured Person	Name and First Name: <input type="checkbox"/> M <input type="checkbox"/> W	Date of birth:	Social insurance No.:
	Street:		
	Postal code:		
	City:		
3. Date of the accident	Day/month/year:	time (hrs/mins):	

Indications for the injured person

Kindly fill in **the claim number** – referenced in all our correspondence – on the accident and pharmacy forms and indicate it each time.

Please retain the accident form for the duration of the treatment; it must be presented to your doctor at each visit and handed to your employer when the treatment is finished. The accident form does not guarantee any entitlement to benefits.

Should you **change doctor**, please contact the insurance immediately.

As your compulsory accident insurance, we will cover your medical costs in a general ward in case of hospitalisation. For the duration of your stay in hospital, a share of the accommodation costs may be deducted from the daily allowance.

The doctor will indicate the incapacity for work on the accident form. In the case of a partial incapacity for work, the full working hours specified by the doctor must be observed unless he/she indicates otherwise on medical grounds (see the left-hand box below).

The entitlement to the insured daily allowance starts three days after the accident. The daily allowance covers 80% of the insured salary.

Necessary **travel and transport expenses** will be reimbursed. Please choose an appropriate and economical means of transport (e.g. public transport).

Doctor's indications

Date		Incapacity for work		Doctor's signature
of the next appointment	of the visit	Degree	from	
*comments on partial incapacity for work				
1) ____%, i.e ____ h per day at ____%				
2) ____%, i.e ____ h per day at ____%				
3) ____%, i.e ____ h per day at ____%				

Date		Incapacity for work		Doctor's signature
of the next appointment	of the visit	Degree	from	
Medical treatment completed on:		Drugs delivered by (pharmacy's name and address):		

Date: _____

Doctor's stamp: _____

Send to: insured -> doctor -> corporate -> insurance

LAA/UVG Pharmacy Form

Claim No.

Accident Insurer: <input type="checkbox"/> Groupe Mutuel Assurances GMA SA <input type="checkbox"/> Mutuel Assurances SA		
1. Employer	Phone No.:	Policy No.:
_____	Usual place of work of the injured person:	Administrative Unit:

2. Injured Person Name and First Name: <input type="checkbox"/> M <input type="checkbox"/> W	Date of birth:	Social insurance No.:
Street:		
Postal code:		
City:		
3. Date of accident Day/month/year:	time (hrs/mins):	

Indications for the injured person

If medical expenses are covered by the insurance, the pharmacy will give you the drugs prescribed by your doctor without asking for payment.

Please purchase all the drugs at a single pharmacy. This form is for the pharmacy. Kindly fill in the claim number referenced in all our correspondence, or have the pharmacy fill it in for you.

Indications for the pharmacy

If the insurance covers the medical costs, it will notify the injured person. Please ask to see the notification, which is at the same time your payment guarantee, and copy the indicated claim number onto this pharmacy form.

Pharmacy invoice

Date delivered	Type and quantity	Price	
		CHF	Ct.
Please attach prescriptions	Total		

This pharmacy invoice must be sent to the insurance at the end of the treatment, but within three months of the accident at the latest.

You may ask the insurance for a new pharmacy form, if

- ▶ there is not enough room to list all the drugs,
- ▶ drugs have to be delivered after the three-month time limit.

Date: _____

Pharmacy stamp: _____

3	code				
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Postal or bank account No:
If settled via OFAC:

Send to: insured -> pharmacy -> insurance