groupemutuel
fondation collective

Notice of incapacity for work to be completed by the employer

Employer

Company name: _____ Contract No.: _____

Insured person

Name: _____ Social insurance No.: 756._____

First name: _____ Date of birth: _____

Address: _____ Marital status: _____

Postcode/Town: _____ Occupation: _____

Details of the claim

The incapacity for work is due to: ☐ illness ☐ accident

Beginning of the incapacity for work: _____

Periods of incapacity for work: _____ % from _____ to _____

_____ % from _____ to _____

_____ % from _____ to _____

The claim was notified to: ☐ insurance for loss of earnings in case of illness ☐ accident insurance

Insurer: _____

Address: _____

Postcode/Town: _____

Claim No.: _____

Annual salary before the incapacity*: CHF _____

Termination of employment: ☐ yes, date _____ ☐ no

Enclosures

☐ Certificates of incapacity for work

☐ Statements of daily allowance benefits in the event of illness

☐ Statements of daily accident benefits + accident declaration

☐ *In the case of hourly wages, please enclose the salary statements for the last 12 months before the incapacity

Comments

_____

_____

_____

Place and date:

Stamp and signature of the employer:

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Your contact
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