groupemutuel
prévoyance GMP

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 : **Signature of the insured person:**

_____ _____

A fondation administred by Groupe Mutuel Services SA
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