LAA/UVG Minor Accident Declaration Form

Claim No.

Accident Insurer: ☐ **Groupe Mutuel Assurances GMA SA** ☐ **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: ☐ M ☐ W	Date of birth:	Social insurance No.:
	Street:	Civil status:	Nationality: Country of residence:
	Postal code: City:	Phone number: Email:	Children under 18 or, if still in training, under 25 ____ child(ren) ☐ none
3. Employment	Date of employment:	Occupation	☐ Family member, associate ☐ Taxed at source
	Position: ☐ senior executive ☐ middle management ☐ employee/worker ☐ apprentice ☐ intern/trainee Employment contract: ☐ indefinite duration ☐ fixed duration > date of end of contract: ☐ terminated > date of termination:		
	Injured person's working hours: ____hours per week Usual working hours in the company: ____hours per week	Contractual activity rate: ____ % Occupation: ☐ irregular ☐ 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):		☐ In Switzerland ☐ 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? Is there a police report? ☐ yes ☐ no	Names of witnesses? Were the witnesses heard? 1. ☐ yes 2. ☐ 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: ☐ left ☐ right ☐ undefined Additional information: Type of injury:		
10. Doctors' addresses	First aid given by (doctor, hospital, clinic):	Follow-up treatment by (doctor, hospital, clinic):	
11. Other employers	☐ yes, Name/address: ☐ no	**Health insurance:**	
12. Other social security benefits	Is the insured person entitled to a daily allowance or a pension from a private or social insurance? ☐ If so, from which? ☐ No	**CCP or bank account of the injured person:**	

City and date: Stamp and signature:

Send to: insurance mentioned above

LAA/UVG Minor Accident Declaration Form

Employer's copy

Claim No.

Accident Insurer: ☐ **Groupe Mutuel Assurances GMA SA** ☐ **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: ☐ M ☐ W	Date of birth:	Social insurance No.:
	Street:	Civil status:	Nationality: Country of residence:
	Postal code: City:	Phone number: Email:	Children under 18 or, if still in training, under 25 ____ child(ren) ☐ none
3. Employment	Date of employment:	Occupation	☐ Family member, associate ☐ Taxed at source
	Position: ☐ senior executive ☐ middle management ☐ employee/worker ☐ apprentice ☐ intern/trainee Employment contract: ☐ indefinite duration ☐ fixed duration > date of end of contract: ☐ terminated > date of termination:		
	Injured person's working hours: ____hours per week Usual working hours in the company: ____hours per week	Contractual activity rate: ____ % Occupation: ☐ irregular ☐ 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):		☐ In Switzerland ☐ 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? Is there a police report? ☐ yes ☐ no	Names of witnesses? Were the witnesses heard? 1. ☐ yes 2. ☐ 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 of absence:		
9. Injuries	Part of the body injured: ☐ left ☐ right ☐ undefined Additional information: Type of injury:		
10. Doctors' addresses	First aid given by (doctor, hospital, clinic):	Follow-up treatment by (doctor, hospital, clinic):	
11. Other employers	☐ yes, Name/address: ☐ no	**Health insurance:**	
12. Other social security benefits	Is the insured person entitled to a daily allowance or a pension from a private or social insurance? ☐ If so, from which? ☐ No	**CCP or bank account of the injured person:**	

Avenir Assurance Maladie SA – Easy Sana Assurance Maladie SA
Mutuel Assurance Maladie SA – Philos Assurance Maladie SA – SUPRA-1846 SA
AMB Assurances SA – Groupe Mutuel Assurances GMA SA
Mutuel Assurances SA – Groupe Mutuel Vie GMV SA
Foundations managed by Groupe Mutuel:
Groupe Mutuel Prévoyance-GMP – Mutuelle Neuchâteloise Assurance Maladie

LAA/UVG Doctor Form

Claim No.

Accident Insurer: ☐ **Groupe Mutuel Assurances GMA SA** ☐ **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: ☐ M ☐ W	Date of birth:	Social insurance No.:
	Street:	Civil status:	Nationality: Country of residence:
	Postal code: City:	Phone number: Email:	Children under 18 or, if still in training, under 25 ____ child(ren) ☐ none
3. Employment	Date of employment:	Occupation	☐ Family member, associate ☐ Taxed at source
	Position: ☐ senior executive ☐ middle management ☐ employee/worker ☐ apprentice ☐ intern/trainee Employment contract: ☐ indefinite duration ☐ fixed duration > date of end of contract: ☐ terminated > date of termination:		
	Injured person's working hours: ____hours per week Usual working hours in the company: ____hours per week	Contractual activity rate: ____ % Occupation: ☐ irregular ☐ 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):		☐ In Switzerland ☐ 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. 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 of absence:	
8. Injuries	Part of the body injured: ☐ left ☐ right ☐ undefined Additional information: Type of injury:		
9. Doctors' addresses	First aid given by (doctor, hospital, clinic):	Follow-up treatment by (doctor, hospital, clinic):	

Doctor's indications: Part of body injured and type of injury:

Doctor's Bill

A. Benefits according to tarif			B. Medicines and bandages	
Date	Chif. Tarif	Points	Nature and quantity	Price
			Total B	
			Point-tax value	
Please attach X-rays	Total		X CHF	Total A
				Total A+B

Medical treatment completed

☐ Yes
☐ No, probably in _____ weeks

Date:

Doctor's stamp and signature:

Postal or bank account N°

Send to: first attending doctor -> insurance company

Avenir Assurance Maladie SA – Easy Sana Assurance Maladie SA
Mutuel Assurance Maladie SA – Philos Assurance Maladie SA – SUPRA-1846 SA
AMB Assurances SA – Groupe Mutuel Assurances GMA SA
Mutuel Assurances SA – Groupe Mutuel Vie GMV SA
Foundations managed by Groupe Mutuel:
Groupe Mutuel Prévoyance-GMP – Mutuelle Neuchâteloise Assurance Maladie

LAA/UVG Pharmacy Form

Claim No.

Accident Insurer: ☐ **Groupe Mutuel Assurances GMA SA** ☐ **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: ☐ M ☐ 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				

Postal or bank account No:
If settled via OFAC:

Send to: insured -> pharmacy -> insurance