groupemutuel

**Claim No.** _____

# Minor accident declaration report

## Employer

### Company information

| | |
|---|---|
| Company name | _____ |
| Street / Number | _____ |
| Additional address | _____ |
| Postal code / Town | _____ |
| Contract No. | _____ |
| Business Unit | _____ |
| Phone number | _____ |
| Email address | _____ |
| Contact person | _____ |

## Insured person

### Insured's personal information

| | |
|---|---|
| Title | ☐Mrs ☐Mr |
| First name | _____ |
| Surname | _____ |
| Employee ID | _____ |
| Marital status | ☐Single ☐Registered partner ☐Separeted ☐Divorced ☐Widowed ☐Common-law partner ☐Maried |
| Date of birth | Date (dd/mm/yyyy) : _____ |
| Nationality / Residence permit | _____ |
| AHV number | _____ |
| Basic health insurance (LAMal) | _____ |
| Dependent child/children | ☐Yes ☐No |

### Insured's contact details

| | |
|---|---|
| Country of residence | _____ |
| Street / Number | _____ |
| Additional address | _____ |
| Postal code / Town | _____ |
| Phone number | _____ |
| Email address | _____ |

### Bank/postal details

| | |
|---|---|
| To whom should the benefits be paid? | ☐Employer ☐Employee |
| Employee IBAN | _____ |

## Employment

### Contractual information

| | |
|---|---|
| Type of contract | ☐Indefinite duration ☐Definite duration |
| Beginning of employment contract | Date (dd/mm/yyyy) : _____ |
| End of employment contract | Date (dd/mm/yyyy) : _____ |
| Is the contract terminated? | ☐Yes ☐No |
| For which term? | Date (dd/mm/yyyy) : _____ |
| Position | ☐Employee ☐Manager ☐Senior Manager ☐Apprentice ☐Intern |
| Occupation | _____ |
| Usual place of work | _____ |

## Description of the accident

### Working hours

| | |
|---|---|
| Employee's working hours | _____hours/week |
| Contractual activity rate | _____% |
| Usual schedule in the company | _____hours/week |
| Type of job | ☐Regular ☐Irregular |
| Is the company partially unemployed? | ☐Yes ☐No |

### Other employer

| | |
|---|---|
| Company name / First name / Name | _____ |
| Country | _____ |
| Street / Number | _____ |
| Additional adress | _____ |
| Postal code / Town | _____ |

### Data related to the accident

| | |
|---|---|
| Nature of the accident | _____ |
| Last day of work | Date (dd/mm/yyyy) : _____ |
| Time of departure from the workplace | Time (hh:mm) : _____ |
| Date of the accident | Date (dd/mm/yyyy) : _____ |
| Time of the accident | Time (hh:mm) : _____ |
| Reason for the absence | _____ |
| Location / place | _____ |
| Description of the accident | _____ |
| Activity at the time of the accident | _____ |
| Cause of the accident | _____ |

### Police report

| | |
|---|---|
| Was a police report produced? | ☐Yes ☐No |
| Who made the accident report? | _____ |

### Person at fault or involved?

| | |
|---|---|
| Is another person involved in the accident? | ☐Yes ☐No |
| First name | _____ |
| Surname | _____ |
| Country of residence | _____ |
| Street / Number | _____ |
| Additional address | _____ |
| Postal code / Town | _____ |
| First name | _____ |
| Surname | _____ |
| Country of residence | _____ |
| Street / Number | _____ |
| Additional address | _____ |
| Postal code / Town | _____ |

Claim No. _____

## Injuries

### Injuries

| | |
|---|---|
| Is the insured person deceased? | ☐Yes ☐No<br>Date (dd/mm/yyyy) :_____ |
| Part of the body affected | _____ |
| Side of the body | _____ |
| Additional information on injuries | _____ |
| Injury type | _____ |

### Treatment

| | |
|---|---|
| Initial medical treatment | Address:_____ |
| Further medical treatment | Address:_____ |

**Place and date:**

_____

Claim No. _____

# Accident form

## Minor accident

| Employer | | Insured person | |
|---|---|---|---|
| Company name | _____ | Title | _____ |
| Street / Number | _____ | First name | _____ |
| Additional address | _____ | Surname | _____ |
| Postal code / Town | _____ | Date of birth | _____ |
| Contract No. | _____ | AHV number | _____ |
| Business unit | _____ | Phone number | _____ |
| Usual place of work | _____ | Date and time of the accident | _____ |

## Doctor's indications

**Part of body injured and type of injury:**

_____

_____

## Doctor's Bill

**A. Benefits according to tarif**

| Date | Chif. Tarif | Points |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Please attach X-rays **Total**

**B. Medicines and bandages**

| Nature and quantity | Price |
|---|---|
| | |
| | |

**Total B**

Point-tax value

x CHF

Total A

**Total A + B**

**Medical treatment completed**

☐ Yes

☐ No, probably in_____ weeks

Send to: first attending doctor -> insurance company

**Postal or bank account N°**

**Date**

**Doctor's stamp**

Claim No. _____

# Pharmacy Form

## Accident

| Employer | | Insured person | |
|---|---|---|---|
| Company name | _____ | Title | _____ |
| Street / Number | _____ | First name | _____ |
| Additional address | _____ | Surname | _____ |
| Postal code / Town | _____ | Date of birth | [dd/mm/yyyy] :_____ |
| Contract No. | _____ | AHV number | _____ |
| Business Unit | _____ | Phone number | _____ |
| Usual place of work | _____ | Date and time of the accident | [dd/mm/yyyy] :_____ [hh:mm] : _____ |

### 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 | Price Ct. |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | **Total** | | |

Please attach prescriptions

Send to: insured -> pharmacy -> insurance

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

| 3 | code | | | | |
|---|---|---|---|---|---|

Postal or bank account No

If settled via OFAC:

**Date**

**Pharmacy stamp**