groupemutuel

LAA/UVG Accident Declaration Form

Claim No.

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:
Civil status:
Social insurance No.:
Street:
Nationality:
Country of residence:
Type of residence permit:
Postal code:
City:
Phone number:
Email:
Children under 18 or, if still in training jusqu'à 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
Contractual activity rate: %
Usual working hours in the company: hours per week
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?
1.
2.
Were the witnesses heard?
☐ yes
☐ 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. Incapacity for work
Did the person stop work after the accident? ☐ yes, since at % ☐ no
Is the injured person back at work? ☐ yes, since at % ☐ no

11. Doctors' addresses
First aid given by (doctor, hospital, clinic):
Follow-up treatment by (doctor, hospital, clinic):

12. Salary

	CHF rate per	hour	month	year
Base contractual salary (gross)				
Cost of living allowance				
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
☐ yes, Name/address :
☐ 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?
☐ If so, from which?
☐ No
CCP or bank account of the injured person (Reimbursement of treatment bills):

Send to: insurance mentioned above

City and date :

Stamp and signature :

A company under Groupe Mutuel Holding SA
Groupe Mutuel Assurances GMA SA
Rue des Cèdres 5, 1920 Martigny
www.groupemutuel.ch

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Employer's copy

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Administrative Unit:

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Civil status:
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Street:
Nationality:
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Type of residence permit:
Postal code:
Phone number:
Children under 18 or, if still in training jusqu'à under 25 child(ren) ☐ none
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☐ 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?
Names of witnesses?
1.
2.
Were the witnesses heard?
☐ yes
☐ no
Is there a police report? ☐ yes ☐ 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:

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Did the person stop work after the accident? ☐ yes, since at % ☐ no
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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
☐ yes, Name/address :
☐ 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?
☐ If so, from which?
☐ No
CCP or bank account of the injured person (Reimbursement of treatment bills):

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LAA/UVG Accident Form

Claim No.			
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:
	Stree:		
	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		
of the next appointment	of the visit	Degree	from	Doctor's signature

Date		Incapacity for work		
of the next appointment	of the visit	Degree	from	Doctor's signature

Medical treatment completed on:	Drugs delivered by (pharmacy's name and address)

* comments on partial incapacity for work

1)	%,i.e..	h per day qt	%	
2)	%,i.e..	h per day qt	%	
3)	%,i.e..	h per day qt	%	

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

Date :	Doctor's stamp:

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LAA/UVG Pharmacy Form

Claim No.			
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:
	Stree:		
	Postal code: City:		
3. Date of the 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**		

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 :

Timbre de la pharmacie :

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