groupemutuel
fondation collective

Notice of incapacity for work to be completed by the insured person

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_____

_____ % from _____ to_____

_____ % from _____ to_____

Comments

_____

_____

_____

Authorisation

The undersigned authorises the Fondation Collective Groupe Mutuel to request any useful information concerning the claim and to access to the records of the disability insurance (AI/IV) office, accident insurance, military insurance, LAMal/KVG or LCA/VVG loss of earnings insurance, any foreign social insurance or other insurers, to ask for information from the person's attending doctors and to share these documents and information with the reinsurer and other insurers as appropriate.

Place and date: **Signature of the insured person:**

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Your contact
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