Groupe Mutuel
PRÉVOYANCE PREVIDENZA VORSORGE

Notification of incapacity for work

Name, First name: ______________________ AVS N°: ______________
Postal code/ place: ______________________ Street, number: ______________
Profession: ______________________ Contract N°: ______________

1. Start of incapacity to work (day/month/year) ______________________

2. Is the incapacity to work due to ☐ disease ☐ accident

3. The insured event was declared to
   - ☐ disability insurance AI/IV on ______________
   - ☐ accident insurance on ______________
   - ☐ military insurance on ______________
   - ☐ health insurance daily allowance on ______________

   (Name/Agency): ______________

   (join a copy of the decision and/or the statement of benefits)

4. Degree of incapacity
   - _____% from ______________ to ______________
   - _____% from ______________ to ______________
   - _____% from ______________ to ______________

5. Names and addresses of attending doctors (attach medical report and/or accident form)

   ____
   ____
   ____

6. Minors and children in apprenticeship or who are studying (attach a certificate of apprenticeship or a school certificate)

Name and first name:	Date of birth:
______________________	______________
______________________	______________
______________________	______________

7. Authorisation

   The undersigned authorises Groupe Mutuel Prévoyance to request any information required to evaluate the claim, to review the files held by the disability insurance (AI/IV), the accident insurance, the military insurance, the health insurance (LAMal/KVG or LCA/VVG) or a possible foreign social insurance or other insurers, to request information from attending doctors, to request medical examinations and to forward the documents and information to a reinsurer or other relevant insurers.

Place and date:	Member's signature:

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Groupe Mutuel Prévoyance
Rue du Nord 5
1920 Martigny

8. **Has employment terminated?** ☐ yes ☐ no

If so, on which date? ____________________

9. **Benefits are payable:**

to postal account N°: ____________________

to bank account N°: ____________________

in favour of: ____________________

(The pension plan pays benefits directly to the member)

10. **To be completed by the employer**

Period of activity preceding the incapacity to work: ______________ au ______________

Corresponding AVS/AHV salary CHF ____________________

Comments:

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Appendixes:

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Place and date:	Employer's signature: