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Earning incapacity declaration

Employer

Company | Contract N°

Information concerning the insured person

Last

First name

AVS N° . . . | Date of birth D D / M M / Y Y Y Y

E-mail | Telephone

Address

Insurance company

Health loss of earnings (name and address)

Accidents (UVG) (name and address)

Information concerning incapacity and professional situation

Reason for the earning incapacity ☐ illness ☐ accident

Degree and duration (%) . | from D D / M M / Y Y Y Y to D D / M M / Y Y Y Y

. | from D D / M M / Y Y Y Y to D D / M M / Y Y Y Y

. | from D D / M M / Y Y Y Y to D D / M M / Y Y Y Y

Name and address of the attending physician

Include daily benefit statements and medical certificates.

Professional situation

Professional activity pursued prior to the earning incapacity?

Will the person insured be able to resume the same professional activity? ☐ yes ☐ no

Has the employment contract been terminated? ☐ yes ☐ no | If yes, when? D D / M M / Y Y Y Y

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Earning incapacity declaration

Declaration by the insured person regarding exemption from the obligation of medical confidenti

I, the undersigned,

authorise the doctors, hospitals and other stationary facilities (e.g. nursing homes for seniors, whether medical or not), the employer, government offices and authorities (e.g. the Office for Social Affairs, social services), the disability insurance (AI)/old-age and surviving dependents insurance (AVS), life insurances, private or compulsory accident insurance, the unemployment insurance fund, any other private insurance involved (e.g. the daily benefits insurance for illness) and their employees to suspend their obligation to maintain medical confidentiality and to provide information to the Fondation Collective Opsion, its reinsurer and its authorised representatives, to consult their files and transmit copies of documents. The Fondation Collective Opsion undertakes to treat the information and documents received in conformity with the law on data protection.

Furthermore the undersigned authorises the Fondation Collective Opsion to provide information and/or documents to the disability insurance, to the compulsory or private accident insurance or to any liable party or liability insurance (as a basis for appeal).

Signatures

The undersigned attest, on their honour, to the accuracy of the above information.

Date / / Place	Signature of the insured
Date / / Place	Stamp, signature of employer