groupemutuel

Medical certificate of incapacity for work

Ref. N° (to be filled in by Insurer)			
1. Insured	Name, first name	Date of birth	
	Street	Phone N°	Insurance N°
	Postal code Town	Usual professional activity	
2. Employer	Name, address and postal code		
3. Start of incapacity	Day/month/year	hour, minute	expected duration, to the best of your knowledge

Indications for the insured
Kindly fill in the Insurance N°– referenced in all our correspondence – on this form and indicate it each time.
This "certificate of incapacity for work" has to be filled in by your doctor at each visit. **A copy must be sent to the Insurer once a month for advances on daily allowances.** You must keep the original until the end of the incapacity for work, and then send it promptly to the Insurer.
The insured must notify the Insurer immediately if there is a change in the degree of incapacity for work.

Doctor's indications
☐ Illness ☐ Accident ☐ Industrial illness ☐ Maternity, presumed date of confinement

Date		Incapacity for work		Doctor's signature	Date		Incapacity for work		Doctor's signature
of the next appointment	of the visit	Degree	From		of the next appointment	of the visit	Degree	From	
					Medical treatment completed on				

Doctor's stamp