groupemutuel

Claim No. _____

Accident declaration report

Employer

Company information

Company name	_____
Street / Number	_____
Additional address	_____
Postal code / Town	_____
Contract No.	_____
Business Unit	_____
Phone number	_____
Email address	_____
Contact person	_____

Insured person

Insured's personal information

Title	☐Mrs ☐Mr
First name	_____
Surname	_____
Employee ID	_____
Marital status	☐Single ☐Registered partner ☐Separeted ☐Divorced ☐Widowed ☐Common-law partner ☐Maried
Date of birth	Date (dd/mm/yyyy) : _____
Nationality / Residence permit	_____
AHV number	_____
Basic health insurance (LAMal)	_____
Dependent child/children	☐Yes ☐No
Are you receiving any benefit from another social insurance?	☐Yes ☐No
Type of benefit	☐AI/IV-AVS/AHV ☐SUVA or other LAA/UVG insurer ☐Personal/private insurance ☐Unemployment insurance ☐LPP/BVG ☐Military insurance ☐Other

Insured's contact details

Country of residence	_____
Street / Number	_____
Additional address	_____
Postal code / Town	_____
Telephone number	_____
Email address	_____

Bank/postal details

To whom should the benefits be paid?	☐Employer ☐Employee
Employee IBAN	_____

Employment

Contractual information

Type of contract	☐Indefinite duration ☐Definite duration
Beginning of employment contract	Date (dd/mm/yyyy) : _____
End of employment contract	Date (dd/mm/yyyy) : _____
Is the contract terminated?	☐Yes ☐No
For which term?	Date (dd/mm/yyyy) : _____
Position	☐Employee ☐Manager ☐Senior Manager ☐Apprentice ☐Intern

Occupation	_____
Usual place of work	_____

Working hours

Employee's working hours	_____hours/week
Contractual activity rate	_____%
Usual schedule in the company	_____hours/week
Type of job	☐Regular ☐Irregular
Is the company partially unemployed?	☐Yes ☐No
Number of home office days per week	_____ days

Other employer

Company name / First name / Name	_____
Country	_____
Street / Number	_____
Additional address	_____
Postal code / Town	_____

Description of the accident

Data related to the accident

Nature of the accident	_____
Last day of work	Date (dd/mm/yyyy) : _____
Time of departure from the workplace	Time (hh:mm) : _____
Date of the accident	Date (dd/mm/yyyy) : _____
Time of the accident	Time (hh:mm) : _____
Reason for the absence	_____
Location / place	_____
Description of the accident	_____
Activity at the time of the accident	_____
Cause of the accident	_____

Police report

Was a police report produced?	☐Yes ☐No
Who made the accident report?	_____

Person at fault or involved?

Is another person involved in the accident?	☐Yes ☐No
First name	_____
Surname	_____
Country of residence	_____
Street / Number	_____
Additional address	_____
Postal code / Town	_____
First name	_____
Surname	_____
Country of residence	_____
Street / Number	_____
Additional address	_____
Postal code / Town	_____

Claim No. _____

Injuries

Injuries

Is the insured person deceased?	☐Yes ☐No Date (dd/mm/yyyy) : _____
Part of the body affected	_____
Side of the body	_____
Additional information on injuries	_____
Injury type	_____

Treatment

Initial medical treatment	Address:_____
Further medical treatment	Address: _____

Incapacity for work

Incapacity for work

Beginning of the incapacity	Date (dd/mm/yyyy) : _____ Time (hh:mm) : _____
Rate of incapacity	_____%

Return to work

Effective date of return to work	Date (dd/mm/yyyy) : _____

Salaries

Salary data

Subject to withholding tax	☐Yes ☐No
Amount of gross salary	_____
Payment frequency	☐Annual ☐Hourly ☐Monthly ☐Daily
Bonus, 13th month's salary (and following)	_____
Payment frequency	☐Annual ☐Hourly ☐Monthly ☐Percentage

Other benefits

Holiday allowance, public holidays allowance	_____
Payment frequency	☐Annual ☐Hourly ☐Monthly ☐Percentage
Child and family allowances	_____
Payment frequency	☐Annual ☐Hourly ☐Monthly
Cost-of-living allowance	_____
Payment frequency	☐Annual ☐Hourly ☐Monthly
Other salary supplements	_____
Total amount of other salary supplements	_____
Payment frequency	☐Annual ☐Hourly ☐Monthly

Place and date:

_____

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Claim No. _____

Accident form

Accident with incapacity

Employer		Insured person	
Company name	_____	Title	_____
Street / Number	_____	First name	_____
Additional address	_____	Surname	_____
Postal code / Town	_____	Date of birth	[dd/mm/yyyy] :_____
Contract No.	_____	AHV number	_____
Business Unit	_____	Phone number	_____
Usual place of work	_____	Date and time of the accident	[dd/mm/yyyy] :_____ [hh:mm] : _____

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
* 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 ___ %				

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)		

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

Date	Doctor's stamp

Claim No. _____

Pharmacy Form

Accident

Employer		Insured person	
Company name	_____	Title	_____
Street / Number	_____	First name	_____
Additional address	_____	Surname	_____
Postal code / Town	_____	Date of birth	[dd/mm/yyyy] :_____
Contract No.	_____	AHV number	_____
Business Unit	_____	Phone number	_____
Usual place of work	_____	Date and time of the accident	[dd/mm/yyyy] :_____ [hh:mm] : _____

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	Price Ct.
	Total		

Please attach prescriptions

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

Pharmacy stamp