Groupe Mutuel
Assurances
Versicherungen
Assicurazioni

Avenir Assurance Maladie SA – Easy Sana Assurance Maladie SA
Mutuel Assurance Maladie SA – Philos Assurance Maladie SA – SUPRA-1846 SA
AMB Assurances SA – Groupe Mutuel Assurances GMA SA
Mutuel Assurances SA – Groupe Mutuel Vie GMV SA
Foundations managed by Groupe Mutuel: Groupe Mutuel Prévoyance-GMP
Mutuelle Valaisanne de Prévoyance – Mutuelle Neuchâteloise Assurance Maladie

LAA/UVG Accident Declaration Form

Claim N°

Accident Insurer: ☐ Groupe Mutuel Assurances GMA SA ☐ Mutuel Assurances SA

1. Employer

Phone N° :

Policy N° :

Injured person's usual work place (business sector/ administrative unit)

2. Injured person

Name and First Name: ☐ M ☐ W

Date of birth:

N° AVS/AHV N°:

Street:

Civil status:

Nationality:

Postal code:
City:

Phone N°:
Email:

Children under 18 or, if still in training, under 25 ____ child(ren) ☐ none

3.Employement

Date of employment:

Profession exercised:

☐ Family member, associate
☐ Taxed at source

Position: ☐ senior executive ☐ middle management ☐ employee/worker ☐ apprentice ☐ intern/trainee
Employment contract: ☐ indefinite duration ☐ fixed duration ☐ terminated

Injured person's working hours: _____ hours per week
Contractual degree of employment: ______ percent
Usual working hours in the company: ____ hours per week
Occupation: ☐irregular ☐partially unemployed

4. Date of the accident

Day/month/year:

time (hrs/mins):

5. Site of the accident

Location (name or postal code) and city (e.g. workshop, office, street):

6. Facts (accident description)

What was the injured person doing when the accident happened; description of the accident and of any persons, objects or vehicles involved: ______________________________

____

____

7. Report

Who made the report?

Is there a police report? ☐ yes ☐ no

Names of witnesses?
1.
2.

Were the witnesses heard?
☐ yes
☐ no

8. Non work accident

When was the last time the injured person was at work at the Company before the accident (day, date, time)?
Until:
Ground for absence:

9. Injuries

Part of the body injured: ☐ left ☐ right ☐ undefined

Type of injury:

10. Incapacity for work

Work interrupted following the accident? ☐ yes ☐ no If so, since when? ______________
Is the injured person back at work? ☐ no ☐ yes since ____________ at ____ %

11. Doctors' adresses

First aid given by (doctor, hospital, clinic):
____

Follow-up treatment by (doctor, hospital, clinic):
____

12. Salary

	CHF rate per	hour	month	year
Base contractual salary (gross)				
Cost of living allowance				
Family, child allowances				
Holiday and public holiday allowance in % or				
Bonus, 13th month salary (and others) in % or				
Other additional remuneration (e.g. per assignment/commissions/in kind/ allowance for shift work)				
Designations:				

13. Other employers

☐ yes ☐ no
Name/adress______________________________

Health insurance:
____

14. Other social security benefits

Is the insured person entitled to a daily allowance or a pension from a private or social insurance?
☐ If so, from which ______________________________
☐ No

Injured person's postal or bank account N°
____

City and date: ______________

Stamp and signature: ______________

Send to: insurances mentioned above

2018

Groupe Mutuel
Rue des Cèdres 5 – P.O. Box - CH-1919 Martigny

LAA/UVG Accident Declaration Form
Employer's copy

Claim N°

Accident Insurer: ☐ Groupe Mutuel Assurances GMA SA ☐ Mutuel Assurances SA

1. Employer		Phone N° :	Policy N° :
		Injured person's usual work place (business sector/ administrative unit):	
2. Injured person	Name and First Name: ☐ M ☐ W	Date of birth:	N° AVS/AHV N° :
	Street:	Civil status:	Nationality:
	Postal code: City:	Phone N°: Email :	Children under 18 or, if still in training, under 25 ____ child(ren) ☐ none
3.Employement	Date of employment:	Profession exercised:	☐ Family member, associate ☐ taxed at source
	Position: ☐ senior executive ☐ middle management ☐ employee/worker ☐ apprentice ☐ intern/trainee Employment contract: ☐ indefinite duration ☐ fixed duration ☐ terminated		
	Injured person's working hours: _____ hours per week Usual working hours in the company: ____ hours per week		Contractual degree of employment: ______ percent Occupation: ☐irregular ☐partially unemployed
4. Date of the accident	Day/month/year:		time (hrs/mins):
5. Site of the accident	Location (name or postal code) and City (e.g. workshop, office, street):		
6. Facts (accident description)	What was the injured person doing when the accident happened; description of the accident and of any persons, objects or vehicles involved: ____		
7. Report	Who made the report? Is there a police report? ☐ yes ☐ no	Names of witnesses? 1. 2.	Were the witnesses heard? ☐ yes ☐ no
8. Non work accident	When was the last time the injured person was at work at the Company before the accident (day, date, time)? Until:		Ground for absence:
9. Injuries	Part of the body injured:		☐ left ☐ right ☐ undefined
	Type of injury:		
10. Incapacity for work	Work interrupted following the accident? ☐ yes ☐ no Is the injured person back at work? ☐ no ☐ yes		If so, since when? ____ since ____ at ____ %
11. Doctors' adresses	First aid given by (doctor, hospital, clinic) ____		Follow-up treatment by (doctor, hospital, clinic): ____

12. Salary

	CHF rate per	hour	month	year
Base contractual salary (gross)				
Cost of living allowance				
Family, child allowances				
Holiday and public holiday allowance in % or				
Bonus, 13th month salary (and others) in % or				
Other additional remuneration (e.g. per assignment/commissions/in kind/ allowance for shift work)				
Designations:				

13. Other employers	☐ yes ☐ no Name/adress____	**Health insurance :** ____
14. Other social security benefits	Is the insured person entitled to a daily allowance or a pension from a private or social insurance? ☐ If so, from which ____ ☐ No	**Injured person's postal or bank account N°:** ____

Avenir Assurance Maladie SA – Easy Sana Assurance Maladie SA
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Groupe Mutuel
Assurances
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LAA/UVG Accident Form

Claim N°

Accident Insurer: ☐ Groupe Mutuel Assurances GMA SA ☐ Mutuel Assurances SA			
Employer		Phone N° :	Policy N° :
		Injured person's usual work place (business sector/ administrative unit):	
Injured person	Name and First Name: ☐ M ☐ W	Date of birth:	N° AVS/AHV N° :
	Street:		
	Postal code: City:	Phone N°: Email:	
Date of the accident	Day/month/year:	time (hrs/mins):	

Indications for the injured person

Kindly fill in the claim N°– referenced in all our correspondence – on the accident and pharmacy forms and indicate it each time.

The accident form remains in your possession for the duration of the treatment; it must be presented to your doctor at each visit and remitted to your employer when the treatment is finished. The accident form does not guarantee any entitlement to benefits.

Should you change practitioner, 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 length of your stay in hospital, a share of the maintenance 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 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, economical means of transport (e.g. public transport).

Doctor's indications

Date		Incapacity for work		Doctor's signature
of the next appointment	Of the visite	Degree	from	
*comments on partial incapacity for work				
1) _______%, i.e ______ h per day at ____%				
2) _______%, i.e ______ h per day at ____%				
3) _______%, i.e ______ h per day at ____%				

Date		Incapacity for work		Doctor's signature
of the next appointment	Of the visite	Degree	from	
Medical treatment completed on:		Drugs delivered by (pharmacy's name and address):		

Doctor's stamp :

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

Groupe Mutuel
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Versicherungen
Assicurazioni

LAA/UVG Phamacy Form

Claim N°

Accident Insurer: ☐ Groupe Mutuel Assurances GMA SA ☐ Mutuel Assurances SA			
Employer		Phone N° :	Policy N° :
		Injured person's usual work place (business sector/ administrative unit):	
Injured person	Name and First Name: ☐ M ☐ W	Date of birth:	N° AVS/AHV N°:
	Street:		
	Postal code: City:		
Date of the accident	Day/month/year:	time (hrs/mins):	

Indications for the injured person

If medical expenses are guaranteed by the insurance, the pharmacy will give you the drugs prescribed by your doctor without demanding payment.

Please purchase all the drugs at a single pharmacy. This form is for the pharmacy. Kindly fill in the claim N° referenced in all our correspondence, or have the pharmacy fill it in for you.

Indications for the pharmacy

If it guarantees the medical costs, the insurance 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 N° onto this pharmacy form.

Pharmacy Bill

Date delivered	Nature and quantity	Price CHF	Ct.

Please attach prescriptions **Total**

This pharmacy bill is to 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, on which the

- there is not enough room to list all the drugs,
- drugs have to be delivered after the three-month time limit.

Date:

Pharmacy stamp :

3	code				

Postal or bank account N°:

If settled via OFAC:

Send to: insured -> pharmacy -> insurance

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Rue des Cèdres 5 – P.O. Box - CH-1919 Martigny