LAA/UVG Accident Declaration Form

Claim No.

Accident Insurer:	**Groupe Mutuel Assurances GMA SA**	**Mutuel Assurances SA**	
1. Employer		Phone No.:	Policy No.:
		Usual place of work of the injured person:	Administrative Unit:
2. Injured person	Name and first name: ☐ M ☐ W	Date of birth: Civil status:	Social insurance No.:
	Street:	Nationality:	Country of residence: Type of residence permit:
	Postal code: City:	Phone number: Email:	Children under 18 or, if still in training, under 25 ____ child(ren) ☐ none
3. Employment	Date of employment:	Occupation	☐ Family member, associate ☐ Taxed at source
	Position: ☐ senior executive ☐ middle management ☐ employee/worker ☐ apprentice ☐ intern/trainee Employment contract: ☐ indefinite duration ☐ fixed duration > date of end of contract: ☐ terminated > date of termination:		
	Injured person's working hours: ____hours per week Usual working hours in the company: ____hours per week	Contractual activity rate: ____ % Occupation: ☐ irregular ☐ partially unemployed	
4. Date of the accident	Day/month/year:	time (hrs/mins):	
5. Place of the accident	Location (name or postal code) and city (e.g. workshop, office, street):		☐ In Switzerland ☐ Abroad
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 prepared the report? Is there a police report? ☐ yes ☐ no	Names of witnesses? Were the witnesses heard? 1. ☐ yes 2. ☐ 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:	Reason for absence:	
9. Injuries	Part of the body injured: ☐ left ☐ right ☐ undefined Additional information: Type of injury:		
10. Incapacity for work	Did the person stop work after the accident? ☐ yes, since ____ at ____ % ☐ no Is the injured person back at work? ☐ yes, since ____ at ____ % ☐ no		
11. Doctors' addresses	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 task/on commission/in kind/allowance for team work) Designations:				

13. Other employers	☐ yes, Name/address: ____ ☐ no	**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	**CCP or bank account of the injured person (Reimbursement of treatment bills):**

Send to: insurance mentioned above City and date: _____ Stamp and signature: _____

LAA/UVG Accident Declaration Form

Employer's copy

Claim No.

Accident Insurer:	**Groupe Mutuel Assurances GMA SA** **Mutuel Assurances SA**		
1. Employer		Phone No.:	Policy No.:
		Usual place of work of the injured person:	Administrative Unit:
2. Injured person	Name and first name: ☐ M ☐ W	Date of birth: Civil status:	Social insurance No.:
	Street:	Nationality:	Country of residence: Type of residence permit:
	Postal code: City:	Phone number: Email:	Children under 18 or, if still in training, under 25 ____ child(ren) ☐ none
3. Employment	Date of employment:	Occupation	☐ Family member, associate ☐ Taxed at source
	Position: ☐ senior executive ☐ middle management ☐ employee/worker ☐ apprentice ☐ intern/trainee Employment contract: ☐ indefinite duration ☐ fixed duration > date of end of contract: ☐ terminated > date of termination:		
	Injured person's working hours: ____hours per week Usual working hours in the company: ____hours per week	Contractual activity rate: ____ % Occupation: ☐ irregular ☐ partially unemployed	
4. Date of the accident	Day/month/year:	time (hrs/mins):	
5. Place of the accident	Location (name or postal code) and city (e.g. workshop, office, street):		☐ In Switzerland ☐ Abroad
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 prepared the report? Is there a police report? ☐ yes ☐ no	Names of witnesses? Were the witnesses heard? 1. ☐ yes 2. ☐ 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: Reason of absence:		
9. Injuries	Part of the body injured: ☐ left ☐ right ☐ undefined Additional information: Type of injury:		
10. Incapacity for work	Did the person stop work after the accident? ☐ yes, since ____ at ____ % ☐ no Is the injured person back at work? ☐ yes, since ____ at ____ % ☐ no		
11. Doctors' addresses	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 task/on commission/in kind/allowance for team work) Designations:			

13. Other employers	☐ yes, Name/address: ____ ☐ no	**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	**CCP or bank account of the injured person (Reimbursement of treatment bills):**

LAA/UVG Accident Form

Claim No.

Accident Insurer: ☐ **Groupe Mutuel Assurances GMA SA** ☐ **Mutuel Assurances SA**			
1. Employer		Phone No.:	Policy No.:
		Usual place of work of the injured person:	Administrative Unit:
2. Injured Person	Name and First Name: ☐ M ☐ W	Date of birth:	Social insurance No.:
	Street: Postal code: City:		
3. Date of the accident	Day/month/year:	time (hrs/mins):	

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 at ____%				
2) ____%, i.e _____ h per day at ____%				
3) ____%, i.e _____ h per day at ____%				

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):		

Date:

Doctor's stamp:

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

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 Neuchâteloise Assurance Maladie

LAA/UVG Pharmacy Form

Claim No.

Accident Insurer: ☐ **Groupe Mutuel Assurances GMA SA** ☐ **Mutuel Assurances SA**			
1. Employer		Phone No.:	Policy No.:
		Usual place of work of the injured person:	Administrative Unit:
2. Injured Person	Name and First Name: ☐ M ☐ W	Date of birth:	Social insurance No.:
	Street: Postal code: City:		
3. Date of accident	Day/month/year:	time (hrs/mins):	

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	Ct.
Please attach prescriptions	**Total**		

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.

Date:

Pharmacy stamp:

3	code					

Postal or bank account No:
If settled via OFAC:

Send to: insured -> pharmacy -> insurance