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 Minor 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:	Profession exercised:
3.Employement	Date of employment:	Other employers: ☐ yes ☐ no Name and address:	
	Position: ☐ senior executive ☐ middle management ☐ employee/worker ☐ apprentice ☐ intern/trainee		
	Injured person's working hours: _____ hours per week		
4. Date of the ac-cident	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. 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:		
8. Injuries	Part of the body injured: ☐ left ☐ right ☐ undefined		
	Type of injury:		
9. Doctors' adresses	First aid given by (doctor, hospital, clinic):	Follow-up treatment by (doctor, hospital, clinic):	
10. Health insurance			

City and date: Stamp and signature:

To obtain reimbursement, the claimant shall provide all requisite documents and specify his/her postal or bank account number.

Send to: insurance mentioned above

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LAA/UVG Minor 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:	Profession exercised:
3. Employement	Date of employment:	Other employers: ☐ yes ☐ no Name and address:	
	Position: ☐ senior executive ☐ middle management ☐ employee/worker ☐ apprentice ☐ intern/trainee		
	Injured person's working hours: ______ hours per week		
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. 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:	
8. Injuries	Part of the body injured:	☐ left ☐ right ☐ undefined	
	Type of injury:		
9. Doctors' adresses	First aid given by (doctor, hospital, clinic):	Follow-up treatment by (doctor, hospital, clinic):	
10. Health insurance			

City and date: Stamp and signature:

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LAA/UVG Doctor 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:	
Employement	Date of employment:	Other employers: ☐ yes ☐ no Name and address:	
	Position: ☐ senior executive ☐ middle management ☐ employee/worker ☐ apprentice ☐ intern/trainee		
	Injured person's working hours: _____ hours per week		
Date of the accident	day/month/year:	time (hrs/mins):	
Site of the accident	Location (name or postal code) and city (e.g. workshop, office, street):		
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:		
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:	
Injuries	Part of the body injured:	☐ left ☐ right ☐ undefined	
	Type of injury:		
Doctors' adresses	First aid given by (doctor, hospital, clinic):	Follow-up treatment by (doctor, hospital, clinic):	

Doctor's indications: Part of body injured and type of injury:

Doctor's Bill

A. Benefits according to tarif			B. Medicines and bandages	
Date	Chif. Tarif	Points	Nature and quantity	Price
			Total B	
			Point-tax value	
Please attach X-rays	Total		X CHF	Total A
				Total A+B

Medical treatment completed

☐ Yes
☐ No, probably in _____ weeks

Date

Doctor's stamp and signature

Postal or bank account N°

Send to: first aid doctor -> insurance

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LAA/UVG Pharmacy 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):	
Injuries	Part of the body injured: Type of injury:	☐ left ☐ right ☐ undefined	
Doctors' adresses	First aid given by (doctor, hospital, clinic): _______________	Follow-up treatment by (doctor, hospital, clinic): _______________	

Indications for the injured person

The pharmacy will give you the drugs prescribed by your doctor without demanding payment, if you present this form. Please, purchase all the drugs at a single pharmacy.

Indications for the pharmacy

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, if:

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

Pharmacy Bill

Date delivered	Nature and quantity	Price CHF	Ct.
	Total		

Please attach prescriptions

Date:

Pharmacy stamp:

3	code				

Postal or bank account N°

If settled via OFAC:

Send to: insured -> pharmacy -> insurance