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valitas INDEPENDA

Reporting incapacity to work

Please report any **incapacity to work that lasts (or is it expected to last) longer than 90 days** to us**.** This should be reported as early as possible to ensure that our re-insurer can request and verify the necessary documents from the insurers concerned in good time.

1. Insured person

Company

☐ Mr ☐ Ms

Surname First name

Street

Postcode/City/Country

Date of birth SI number 756.

Tel. no. E-mail

Civil status ☐ single ☐ married ☐ divorced ☐ registered partnership ☐ dissolved partnership ☐ widowed

Support obligation ☐ yes ☐ no

2. Employment details

Date employment began

Employment level (%)

OASI annual salary at the time the incapacity to work started (annual salary x 12 or x 13) CHF

Daily sickness allowance insurance provided by the company? ☐ yes ☐ no

Has the employment relationship with the company been terminated/is it due to be terminated? ☐ yes ☐ no

➔ If yes, from what date?

If the insured person is leaving the company, please include the “Exit notification”. A definitive exit from the pension fund can only occur once the insured person becomes able to work again, or once the federal IV body has made its decision.

3. Details of the incapacity to work

Reason ☐ illness ☐ accident ☐ unclear ☐ occupational illness ☐ maternity leave

Details of condition

12.2022

Surname	First name
SI number 756.	

Previous incapacity to work

from	to	Incapacity to work in %	Doctor providing treatment (name, address)

4. Details of insurance companies involved

Please inform us of the name and claim number (if available) for all insurance companies involved.

☐ Accident insurance

➔ Please include a copy of your application for a daily accident allowance

☐ Daily sickness allowance insurance

➔ Please include a copy of your application for a daily sickness allowance

☐ Military insurance

☐ Federal invalidity insurance

☐ Application was made on _____

☐ Responsible IV office: _____

➔ Please include a copy of your application for federal invalidity insurance

☐ Other (e.g. foreign insurance companies)

➔ Please include a copy of your application

5. Power of attorney/declaration of consent for the insured person

For our re-insurer to perform the necessary investigations, it requires power of attorney/declaration of consent from the insured person.

Please complete the power of attorney/declaration of consent below and submit it with this form, signed by the insured person. If this is not possible, we will request the power of attorney/declaration of consent from the insured person directly.

Surname	First name
SI number 756.	

6. Documents and enclosures

In order to notify the re-insurer of the insured person's incapacity to work, we require copies of the following documents. **Please indicate which documents you are enclosing**:

- ☐ all previous medical certificates
- ☐ application for daily accident or sickness allowance insurance
- ☐ statement of all previous daily allowance payments
- ☐ any application for federal invalidity insurance
- ☐ applications/policies with other insurance companies, if applicable
- ☐ power of attorney/declaration of consent signed by the insured person

Please note that if the information reported is not complete, this may delay processing and lead to longer wait times, e.g. for exemptions from contributions. Thank you for including all available documents with this report and for sending us a copy of any new medical certificates, daily allowance statements etc. as quickly as possible going forward.

Comments

Place, date	Employer's stamp and signature

12.2022