

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	AHV/AVS number		
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

Surname

First name

AHV/AVS number

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

AHV/AVS number

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