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Your Swiss Insurer

Postal address
Helvetia Insurance
P.O. Box 99
8010 Zurich

Incapacity for work or to earn (employee section)

Employer

Company

Contract number

Employee

Policy no.

Title

- ◯ Ms
- ◯ Mr

First name

Last name

Street

No.

Postcode

Place

Country

Date of birth

Marital status

E-mail

Telephone No.

Incapacity for work or to earn

What type of incapacity incapacity for work or to earn do you wish to report?

- ◯ First notification
- ◯ Relapse

Has an application been submitted to the Federal Disability Insurance to claim benefits?

- ◯ Yes
- ◯ No

How was the incapacity for work or to earn triggered?

- ☐ through illness
- ☐ through accident (incl. occupational disease)

In the case of illness

Which illness are you suffering from?

How long have you had the symptoms?

Have you already been treated previously for the same illness?

- ◯ Yes
- ◯ No

When?

Which doctor treated you?

In case of an accident

When did the accident occur?

Where did the accident occur?

Please describe the the course of the accident (incl. persons, property or vehicles involved)

What injuries did you suffer in the accident?

Is there a liable third party?

- ◯ Yes
- ◯ No

Is there a police report?

- ◯ Yes
- ◯ No

Note: Please enclose documents (decisions, instructions, confirmations) from the accident insurer(s). You can attach the documents as files at the end of this form.

Medical Treatment

When did you first consult a doctor?

Details of doctor

First name

Last name

Street | No.

Postcode | Place

☐ I am currently undergoing treatment or check-ups with this doctor.

Have you consulted or involved other doctors?

○ Yes

○ No

Details of other doctors

When?

First name | Last name

Street | No.

Postcode | Place

☐ I am currently undergoing treatment or check-ups with this doctor.

When?

First name | Last name

Street | No.

Postcode | Place

☐ I am currently undergoing treatment or check-ups with this doctor.

Dependent children

Have you any dependent children for which a claim is being made for benefits?

○ Yes

○ No

First name | Last name | Date of birth

First name | Last name | Date of birth

First name	Last name	Date of birth
First name	Last name	Date of birth
First name	Last name	Date of birth

Note: Please enclose a copy of the family record booklet. For children in education who are older than the age limit stipulated in the regulations or the in the insurance contract we also require confirmation from the relevant educational institution. You can attach the documents as files at the end of this form.

Power of attorney

Pursuant to the regulations of your employee benefit institution or your autonomous or semi-autonomous foundation, Helvetia Swiss Life Insurance Company Ltd (hereinafter “Helvetia”) is responsible for managing the employee benefit institution or is responsible for the administration and settlement of claims on behalf of the autonomous/semi-autonomous foundation.

By signing this power of attorney you hereby authorise Helvetia, in its function as Managing Director of the employee benefit institution or as the entity entrusted with the administration and settlement of claims on behalf of the autonomous/semi-autonomous foundation, to process the data required for the clarification of your entitlement to benefits and settlement of the claim filed.

Furthermore, you authorise Helvetia to assess any entitlements to benefits you may have from Helvetia with regard to the Federal Insurance Contract Act on the basis of data obtained and, if necessary, to coordinate claims on the employee benefit institution and Helvetia.

Through this power of attorney, Helvetia is also expressly authorised to obtain relevant information and data as well as to inspect and be provided with relevant records (of a medical, professional, financial and legal nature, such as medical reports and reports of vocational guidance) from all public and private-sector insurance institutions (insurance companies and insurance institutions such as Swiss Federal Disability Insurance, Swiss Federal Accident Insurance, Swiss Federal Military Insurance, accident and health insurance companies, daily allowance insurers, co-insurers or reinsurers, employee benefit institutions, etc.) involved in these claims, as well as from the treating physicians, other healthcare providers, hospitals, medical institutions, employers, government agencies and authorities, such as residents' registration offices and investigative authorities, debt enforcement offices, tax authorities, etc. (hereinafter “third parties”).

You hereby authorise these third parties to give Helvetia or its medical service, upon request, the data required to clarify and process the claim and to transmit all relevant records and expressly release these third parties from their legal and contractual duty of confidentiality and secrecy.

The third parties authorised to disclose information may transmit all data and records relevant to the settlement of the claim filed to Helvetia, even without the submission of a new request.

Finally, you hereby authorise Helvetia to transmit all data relevant to settlement of the filed claim to the third parties involved in Switzerland and abroad.

In the event of failure to provide the present power of attorney, Helvetia will not be able to make the necessary inquiries, which may result in insufficient clarification of the scope of the earning disability and therefore lead to rejection of the claim for insurance benefits. Your authorisation is independent of any obligation to pay benefits on the part of your employee benefit institution.

First name _____ Last name _____ Date of birth _____

Contract number _____ Policy no _____

Further comments _____

With their signature the insured confirms that they have provided all of the information truthfully and hereby grants the above-mentioned person full power of attorney.

Place and date

Signature of the insured person or legally appointed representative