

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 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 authorize the employee benefit institution to transmit your personal data, including your sensitive personal data, to Helvetia. You also authorize Helvetia 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 authorize Helvetia to transmit all data relevant to settling the notified benefit case, including sensitive personal data, to the involved third parties in Switzerland and abroad, and to forward this data to the occupational benefits expert or the auditors on the basis of legal requirements.

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 incapacity for work or to earn 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 your signature, you confirm that all the information provided is true and give the above power of attorney in full.

Place and date _____

Signature of the insured person or legally appointed representative _____

Data protection

All personal data will be processed in accordance with the current legislation:

For compulsory occupational benefits, the data protection regulations of LOB (Art. 85a ff. LOB) apply. The provisions of the FADP apply in addition. The FADP applies to purely supplementary occupational benefits (for information e.g. identity and contact details of responsible persons, processing purposes, etc. please see www.helvetia.ch/privacy).