Postal address
Servisa Foundations
P.O. Box 99
8010 Zurich

Incapacity for work or to earn (employer 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.

Employment relationship

What was the annual salary and degree of employment at or just before the onset of the incapacity for work or to earn?

Annual salary

Degree of employment as %

Profession/function

Has the employment contract with the employee been terminated?

◯ Yes

◯ No

Date of termination of employment relationship

_____

Is the employment contract expected to be terminated?

◯ Yes

◯ No

Date of planned termination of employment relationship

_____

Incapacity for work or to earn

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

◯ First notification

◯ Relapse

How was the incapacity for work or to earn triggered?

☐ through illness

☐ as a result of an accident

During which period and to what degree was the insured person unable to work or earn an income?

from	to	Degree of incapacity for work or incapacity to earn in %
from	to	Degree of incapacity for work or incapacity to earn in %
from	to	Degree of incapacity for work or incapacity to earn in %
from	to	Degree of incapacity for work or incapacity to earn in %
from	to	Degree of incapacity for work or incapacity to earn in %

Insurance institutions involved in this case:

In the case of illness

Daily sickness benefits insurance provider

_____

Reference or claim number

_____

Contact person

First name

_____

Last name

_____

E-mail

_____

Telephone no.

_____

For the accident

Accident insurer

Accident number

Contact person

First name

Last name

E-mail

Telephone no.

Has a report been submitted to Federal invalidity insurance for early detection purposes?

◯ Yes

◯ No

Is a report for early detection purposes planned?

◯ Yes

◯ No

Is Military insurance involved?

◯ Yes

◯ No

Contact person

For further information please provide your contact details or the contact details of the responsible contact person at your employer's company.

First name

Last name

E-mail

Telephone no.

Other details

Daily benefits statements of loss of earnings insurer(s) providing benefits

Please enclose copies of daily benefits statements from the onset of the incapacity for work until today.

Other details of the employee

Note: In order to definitively enter the incapacity for work or incapacity to earn you reported, we need additional information from the employee concerned.

How should the employee receive the relevant form?

◯ The company will hand the necessary form out to the employee.

○ The employee should receive the form by e-mail.

○ The foundation should inform employees about the registration formalities by post.

Employee’s private e-mail address

Please give the following form to your employee for further details of the incapacity for work or to earn. This form must be completed and signed by your employee and then returned to us.

Form for incapacity for work or incapacity to earn – employee section

Comments

Further comments

Confirmation employer

☐ The company hereby confirms that all details are truthful and accurate.

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. can be found under the keyword data protection at www.servisa.ch.