

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 earn?	at or just before the onset of the incapacity for work or to		
Annual salary	Degree of employment as %		
Profession/function			



Has the	employment contract with the Yes	employee been ter	minated?			
	termination of employment rel	ationship				
0	mployment contract expected Yes No planned termination of employ					
Incapa	Incapacity for work or to earn					
What typ	pe of incapacity for work or to First notification Relapse	earn do you wish to	report?			
How wa	s the incapacity for work or to through illness as a result of an accident	earn triggered?				
During v	which period and to what degr	ree was the insured person unable to w		ork or earn an income? 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		vider	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? \bigcirc \bigcirc No Is a report for early detection purposes planned? \bigcirc \bigcirc No Is Military insurance involved? Yes \bigcirc \bigcirc 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.



\circ	The employee should receive the form by e-mail.		
\circ	The foundation should inform employees about the registration formalities by post.		
Emplo	byee'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.