

Claim notice for Accident Insurance (LAA/UVG)

		Direction	Claim No.					
1. Employer	Name and adress with zip code		Phone No.	Policy No.				
			Usual place of work of the insured person (depart./sect.)					
2. Insured Person	Name / Firstname		Dath of birth	AHV-No. / AVS No.				
	Road		Phone No.	Place of origin				
	Zip Code	City	Civil status	Nationality				
	Name of insured category		Children < 20 years old or < 25 years old still at s <input type="checkbox"/> number <input type="checkbox"/> none					
3. Employment	Date of beginning of employment	Usual professional activity	<input type="checkbox"/> qualified <input type="checkbox"/> semi-quali.					
			<input type="checkbox"/> not quali. <input type="checkbox"/> Apprentice					
4. Date of accident	Day	Month	Year	Time (Hour, Minute)				
5. Place of accident	Where did the accident take place (locality, place)							
6. Accident descript.	Activity at the moment of the accident, circumstances, involved persons, machines, instruments, vehicle, material							
7. Investigations	Have investigations been made ?		Name of witnesses	Have they been questioned?				
	Are investigations required? <input type="checkbox"/> 'es <input type="checkbox"/> o		<input type="checkbox"/> yes <input type="checkbox"/> io					
8. Non-occupational accident	When did the insured person work for the employer the last time before the accident (Day, Date, Time)?							
	Dath			Time				
9. Injury	Part of the body injured (right / left)		Type of injury					
10. Incapacity to work	Has the activity been suspended as a result?		If yes, since when ? (Date and hour)					
	<input type="checkbox"/> yes <input type="checkbox"/> no							
11. Doctor's adress	Doctor or hospital for the first treatm.		Doctor or hospital for further treatment					
12. Working time of the insured person	Days per week	hours per week	Usual number of working hours p. week in the comp.	Occupation				
				<input type="checkbox"/> irregular <input type="checkbox"/> short-time work				
13. Salary	in cash	Salary (gross)	CHF per	Hour	Day	Month	Year	
		Allowance for adjustment to cost of living						
		Commissions						
		Family / Children allowance						
		Allowance for holiday % oder						
		Other allowances % oder						
		Bonus / 13th salary						
		in kind	Typ					
	Special case	<input type="checkbox"/> Family member <input type="checkbox"/> Associate <input type="checkbox"/> voluntarily ins. Person <input type="checkbox"/> seasonal job <input type="checkbox"/> liable to withholding tax						
		Other employer			Tarif			
14. Other benefits from other social security schemes	Is the insured person already entitled to daily allowances or a pension from: medical care insurance, mandatory accident ins. (UVG), Old age&Survivors Social Insurance, military insurance, Unemployment ins.?							
	If yes, which one?							
	Name of the medical care insurance							

Place and Date	Signature of the insured person	Stamp and signature of the employer
7/1/2019		