



Notification of incapacity for work (Employer's form)

Company _____ Contract no. _____

Contact person _____ Phone Nr. _____

Personal details of insured person

Last name _____ First name _____

Date of birth _____ Social security no 756. _____

Street/no. _____ Postcode/Town _____

Tel. no. _____

Information on the employment relationship

Degree of employment in the company before the occurrence of the incapacity for work _____ %

Insured person's AHV annual salary at the start of the incapacity for work CHF _____

Is the insured person employed by several employers? ☐ yes ☐ no

If yes, which? _____

Was or is the employment relationship terminated? ☐ yes ☐ no

By whom? _____

From when? _____

For what reasons? _____

Information on the incapacity for work (IFW)

IFW due to ☐ illness ☐ accident incl. occupational diseases pursuant to the UVG

Start of IFW _____ Enclose copies of the medical certificates (if available)

Was this a relapse? ☐ yes, first illness from _____ to _____
☐ no

Degree and duration of the incapacity to work **in the case of an employment level of 100%.**

Degree of IFW _____ % from _____ to _____

Degree of IFW _____ % from _____ to _____

Degree of IFW _____ % from _____ to _____

Degree of IFW _____ % from _____ to _____

Other insurance companies with an interest

Has the Swiss federal disability insurance been notified? (With regard to early detection) ☐ yes, on _____ ☐ no

Registration for benefits:

☐ Coll. daily benefits insurance on _____ ☐ Accident insurance (UVG) on _____

☐ Federal disability insurance on _____ ☐ Federal military insurance on _____

Contact coll. daily benefits insurance/accident insurance:

Name of the insurance company _____ P.O. Box _____

Policy number _____ Street / no. _____

Postcode / Town _____

Please forward copies of any daily benefits statements and / or decisions that you **already have** and that you receive **in the future.**

Comments

Note

If an insured person is at least 40% incapable for work for more than 60 days within a 90-day period, this must be reported.

At the same time as registering with Swisscanto 1e Collective Foundation, please ask the insured person to notify the federal disability insurance (IV) to ensure early registration. This ensures that contact is made as soon as possible with the insured person whose capacity for work is limited due to health reasons and who runs the risk of a chronic health problem developing. The employers of the insured person have a duty of notification. The notification can also be made without the agreement of the insured person, as long as they have been informed of this in advance. The notification form (001.100 – Notification form for adults: early registration) can be found on the website www.ahv-iv.ch. The notification for early registration does not apply as a registration for benefits from the IV.

Please pass on the following form (Form for insured person) to your employee and inform them that it must be submitted directly to the Swisscanto 1e Collective Foundation.

Place, date

Stamp and signature of company

Please complete this in full, sign it and send it plus any enclosures (medical certificates, health or daily benefits statements) by post to the following address:

Swisscanto 1e Collective Foundation
Office
P.O. Box
8152 Glattbrugg