Swisscanto
1e Collective
Foundation

Notification of incapacity for work (Form for insured person)

Employer _____ Contract no. _____

Personal details of insured person

Last name _____ First name _____

Date of birth _____ Social security no. 756. _____

Street / no. _____ Postcode / Town _____

Tel. no. _____ Current job _____

Learnt occupation _____

For part-time employees: Do you work part time for health reasons? ☐ yes ☐ no

If yes, which? _____

Children

Do you have under-age children or full-age children who are studying?

Last name _____ First name _____

Date of birth _____ Social security no. 756. _____

Last name _____ First name _____

Date of birth _____ Social security no. 756. _____

Last name _____ First name _____

Date of birth _____ Social security no. 756. _____

Last name _____ First name _____

Date of birth _____ Social security no. 756. _____

Last name _____ First name _____

Date of birth _____ Social security no. 756. _____

In the case of full-age children, please enclose training certificates.

Incapacity for work

Start of incapacity for work _____

Diagnosis(es) _____

_____

_____

Treating physicians

Names and addresses (incl. hospital departments) _____

_____

_____

Please enclose copies of any medical reports, medical certificates and health or daily benefits statements if available.

Payment

Name of bank/post office _____

Address of bank _____

IBAN number _____ SWIFT/BIC _____

Account holder _____

Comments

_____

_____

_____

Power of attorney

The issuer of the power of attorney hereby authorises Swisscanto 1e Collective Foundation as proxy with respect to confirmation of benefit entitlements within the framework of the social insur ances and in particular of the employee benefits insurance

regarding

Release from professional and/or official confidentiality as well as permission to inspect files

The person signing below hereby authorises Swisscanto 1e Collective Foundation and its reinsurer, Swiss Mobiliar Life Insurance Company Ltd, to obtain directly all the files and information required to check the benefit entitlement from all the doctors, medical service providers, medical officers in private and social insurances, hospitals, sanatoriums and similar institutions that it deems to be necessary. The doctors and the named institutions are therefore released from the duty of confidentiality and/ or professional secrecy vis-à-vis Swisscanto 1e Collective Foundation and its reinsurer without restriction. The person signing below also releases all the health insurance funds, health insurers, daily benefits insurers, accident insurers, IV offices, pension schemes, official offices and authorities (e.g. social security, social and welfare services), life assurances, unemployment insurance funds and other private insurances concerned from their duty of confidentiality and hereby authorises them to provide Swisscanto 1e Collective Foundation and its reinsurer with information as well as the right to view their files and to provide them with copies of documents.

Forwarding files and provision of information

The person signing below hereby authorises the Swisscanto 1e Collective Foundation to provide its reinsurer, its company medical officers, medical review bodies, (social) insurance carriers, other liable bodies or the insurers of the liable bodies (for the verification of relapses) and official authorities with documents about the course of the incapacity for work and files for eligibility checks, in particular medical files, as well as to provide verbal and written information. The enforcement of benefits claims must be made by the insured person and/or their representative irrespective of this authorisation.

Swisscanto 1e Collective Foundation and its reinsurer hereby confirm that they will deal with the information and documents that they receive in accordance with the law on data protection. This power of attorney does not expire upon the death of the principal.

By signing this form, the signatory hereby confers the aforementioned power of attorney and confirms the completeness and correctness of the information contained in the notification of the incapacity for work.

Last name and first name of the insured person	Social security number	Date of birth
Place and date	Signature of the insured person or the legal representative (Please submit certificate of appointment)	

Please complete this in full, sign it and send it plus any encl osures (training certificates for full-age children, medical certificates and reports, health or daily benefits statements) by post to the foll owing address:

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

Reset form Print form