

## Notification of incapacity for work (Employer's form)

Company \_\_\_\_\_ Contract no. \_\_\_\_\_  
 Contact person \_\_\_\_\_ Direct line \_\_\_\_\_

### 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**

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**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 Swisssanto Flex 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](http://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 Swisssanto Flex 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:

Swisssanto Flex Collective Foundation  
of the Cantonal Banks  
Stockerstrasse 33  
P.O. Box  
8021 Zurich

## Notification of incapacity for work (Form for insured person)

Employer \_\_\_\_\_

### 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. \_\_\_\_\_

Last name \_\_\_\_\_ First name \_\_\_\_\_

Date of birth \_\_\_\_\_ Social security no. \_\_\_\_\_

Last name \_\_\_\_\_ First name \_\_\_\_\_

Date of birth \_\_\_\_\_ Social security no. \_\_\_\_\_

Last name \_\_\_\_\_ First name \_\_\_\_\_

Date of birth \_\_\_\_\_ Social security no. \_\_\_\_\_

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

Pensions due for payment should be paid to the following:

Payment details     Post office     Bank    IBAN \_\_\_\_\_  
Name of Bank \_\_\_\_\_    Address \_\_\_\_\_

## Comments

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## Power of attorney

The issuer of the power of attorney hereby authorises Swisscanto Flex Collective Foundation as proxy with respect to confirmation of benefit entitlements within the framework of the social insurances 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 Flex Collective Foundation and its reinsurer 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 Flex 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 Flex 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 Flex 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 Flex 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 enclosures (training certificates for full-age children, medical certificates and reports, health or daily benefits statements) by post to the following address:

Swisscanto Flex Collective Foundation  
of the Cantonal Banks  
Stockerstrasse 33  
P.O. Box  
8021 Zurich