Swisscanto
Flex Collective
Foundation

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 r eported.

At the same time as registering with Swisscanto 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 insur ed 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 advanc e. 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 Flex Collective Foundation.

Place, date	Stamp and signature of company

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

Swisscanto Flex Collective Foundation
of the Cantonal Banks
Office
P.O. Box
8152 Glattbrugg

Reset form Print form

Form to be forwarded to the insured person and submitted directly to the Swisscanto Flex Collective Foundation

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. 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

Pensions due for payment should be paid to the following:

Payment details ☐ Post office ☐ Bank IBAN _____

Name of Bank _____ Adress _____

Comments

_____

_____

_____

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 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 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, (so-cial) 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 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 Flex Collective Foundation
of the Cantonal Banks
Office
P.O. Box
8152 Glattbrugg

Reset form Print form