swisscanto

Swisscanto
Flex Collective Foundation

Notification of incapacity for work (form for employer)

Company _____ Contract no. _____

Contact person _____ Phone (direct) _____

Personal data of the insured person

Surame _____ First name _____

Date of birth _____ Social insurance no. 756. _____

Street/no. _____ Post code/city _____

Phone _____

Information about employment relationship

Percentage of working hours before onset of incapacity for work _____ %

Notified salary of insured person at onset of incapacity for work CHF _____

Does the insured person work for more than one employer? ☐ Yes ☐ No

If so, for whom? _____

Was or will the employment relationship be terminated? ☐ Yes ☐ No

If yes, by whom? _____

As per what date? _____

For what reasons? _____

Information about incapacity for work (IFW)

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

Onset of IFW _____ Enclose copies of medical certificates (if available)

Does this qualify as a relapse? ☐ Yes, ill for first time from _____ to _____
☐ No

Level and duration of incapacity for work **for persons working full-time (100%).**

Level of IFW _____ % from _____ to _____

Level of IFW _____ % from _____ to _____

Level of IFW _____ % from _____ to _____

Level of IFW _____ % from _____ to _____

Other insurance schemes involved

Notification made to federal disability insurance (IV)? (for early detection) ☐ Yes, on _____ ☐ No

Application for benefits:

☐ Group daily sickness benefits insurance on _____ ☐ Accident insurance (UVG) on _____

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

Contact person group daily sickness benefits insurance/accident insurance:

Name of insurance _____ P.O. Box _____

Policy number _____ Street/no. _____

Post code/city _____

Please send us copies of current and future daily benefits statements and/or decisions.

Comments/remarks

Notes

A notification must be submitted if an insured person is at least 40% unable to work for longer than 60 days within a period of 90 days.

At the same time as notifying Swisscanto Flex Collective Foundation, please ask the insured person to apply for early detection with the federal disability insurance (IV). This enables the IV to contact the insured person whose working capacity is restricted for reasons of ill health and who is in danger of becoming chronically ill without delay. Employers of the insured person have notification authorisation. Notification can also be made without the consent of the insured person, provided that they were informed in advance. You can find the notification form (001.100 – Notification form for adults: early detection) at www.ahv-iv.ch. Notification for early detection does not qualify as an application for IV benefits.

Please give the following pages (form for insured person) to your employee, instructing them to submit this form directly to Swisscanto Flex Collective Foundation.

Place, date

Stamp and signature of the company

Please send the completed and signed form with enclosures (medical certificates, statements for daily sickness or daily accident benefits) by post to the following address:

Swisscanto Flex Collective Foundation of the Cantonal Banks
Office
P.O. Box
8152 Glattbrugg
043 210 19 00
flex@pfs.ch

Reset form Print form

Form to be passed on to the insured person for direct submission to Swisscanto Flex Collective Foundation

Notification of incapacity for work (form for insured person)

Employer _____

Personal data of the insured person

Surname _____ First name _____

Date of birth _____ Social insurance no. 756. _____

Street/no. _____ Post code/city _____

Phone _____

For part-time employees: Do you work part-time for reasons of ill health? ☐ Yes ☐ No

If so, which? _____

Information about incapacity for work (IFW)

Onset of IFW _____

Please enclose copies of available medical certificates, accident reports and statements of daily sickness or daily accident benefits.

Remarks

_____

_____

_____

Power of attorney

The principal authorises the representative Swisscanto Flex Collective Foundation to investigate their claims to benefits relating to social insurance schemes and in particular the occupational benefits insurance

regarding

Release from obligation to maintain professional/official secrecy/right of inspection of records

The undersigned person authorises Swisscanto Flex Collective Foundation and its reinsurer to directly collect all the documents and information required for checking the claim to benefits; as it deems necessary from all doctors, medical service providers, company doctors and medical advisors of private and social insurance schemes, hospitals, sanatoriums and similar institutions. Such doctors and institutions are therefore unconditionally released from their obligation to maintain medical confidentiality vis-à-vis Swisscanto Flex Collective Foundation and its reinsurer. The undersigned person also releases health insurance companies, health insurers, daily sickness benefit insurers, accident insurers, IV offices, pension funds, government authorities and offices (e.g. social assistance office, social and welfare service), life insurers, unemployment insurance and other involved private insurers and their staff from their confidentiality obligation and authorises them to provide Swisscanto Flex Collective Foundation and its reinsurer with information and to give them access to their files and copies of documents.

Forwarding of own documents and provision of information

The undersigned person authorises Swisscanto Flex Collective Foundation to send documents about the course of the incapacity for work and the review of entitlement, in particular medical files, to its reinsurer, company doctors, medical assessment centres, (social) insurance carriers, other liable parties or their liability insurers (for the establishment of recourse) and government authorities, and to provide them with written and oral information. The insured person and/or their representatives must assert claims for benefits independently of this authorisation.

Swisscanto Flex Collective Foundation and its reinsurer undertake to treat the information and documents received in compliance with the data protection law. This power of attorney does not lapse upon the death of the principal.

With their signature, the undersigned person grants the aforementioned power of attorney in full and confirms the completeness and accurateness of the information provided in the notification of incapacity for work

Surname and first name of the insured person	Social insurance number	Date of birth

Place, date	Signature of the insured person or their legal representative (submit letter of appointment)

Please send the completed and signed form with enclosures (certificates of training of adult children, medical certificates and reports, statements for daily sickness or daily accident benefits) by post to the following address:

Swisscanto Flex Collective Foundation of the Cantonal Banks
Office
P.O. Box
8152 Glattbrugg
043 210 19 00
flex@pfs.ch

Reset form Print form