ARISCO
RISK CONSULTANTS

NOTIFICATION OF DAMAGE 1/5
Accident report UVG

1. EMPLOYER/CONTRACT HOLDER

Name		Company	
Address		Policy nr.	
Telephone		Claims nr.	
Contact person		Postal/Bank details	
E-mail		Subject to VAT (MwST)	○ Yes ○ No

○ Accident ○ Dental accident ○ Occupational illness ○ Relapse

2. INSURED PERSON

Name/First name		AHV nr./Social security nr.	
Address		Sex	○ Female ○ Male
Postal code/City		Telephone/Mobile	
		E-Mail	
Date of birth		Marital status	Registered partnership
Hometown/Nationality		Mother tongue	
Stay permit	○ A ○ B ○ C ○ Other		
Number of children below age 18 or in education			
Name of the mandatory medical insurance			

3. DATE OF ACCIDENT AND CONSEQUENCES

Date of the accident | Time | Accident location

Description of the accident

Affected body part ○ Left ○ Right ○ Not clear

Doctor's address

First attending doctor

Complection of treatment (doctor or hospital)

Was the accident reported to the police? ○ Yes ○ No By whom?

Is somebody liable for the accident? ○ Yes ○ No Are there any witnesses? ○ Yes ○ No

Name/First name	Name/First name
Address	Address
Postal code/City	Postal code/City
Telephone	Telephone

Is there a liability insurance? ○ Yes ○ No

Name of the insurance company

Policy nr.

ARISCO
RISK CONSULTANTS

NOTIFICATION OF DAMAGE 2/5
Accident report UVG

4. ACTIVITY IN THE COMPANY

Date of employment ○ Unlimited employment contract ○ Limited employment ○ Terminated contract

Professional activity Vocation learnt

Position ○ Higher management ○ Middle management ○ Employer ○ Apprentice

○ Trainee ○ As

○ Place of work abroad

Insured person's working hours Hours per week

○ Regular ○ Irregular ○ Short-time work

Customary company working hours Hours per week Contractual employment level

○ Regular ○ Irregular ○ Short-time work

Usual workplace

When did the insured person last work in the company prior to the accident?

5. INCAPACITY TO WORK

Incapacity to work ○ No ○ Yes – from: Expected duration

Work resumed ○ No ○ Yes – by when?

Salary **CHF**	**per hour**	**per month**	**per year**
Contractual base salary incl. indexation (gross)			
Allowance for children/family			
Compensation for holidays/bank holidays in % or CHF			
Gratuity/13. monthly salary (and others) in % or CHF			
Other salary allowances (commission/			
payment per kind/shift premium) – What?			

○ Special cases ○ Volontary employer insurance ○ Family member

Other employers ○ No ○ Yes – when non-occupational accident: by which employer has the insured person worked

Other insurance benefits:
Is the insured person already entitled to daily allowance or pension by means of: health insurance, SUVA or other compulsory accident insurance, disability insurance, old-age and survivor's insurance, military insurance, unemployment insurance. If yes: name of the insurance company

○ No ○ Yes – Insurance company

6. Remarks

By signing this document you empower the insurance company to get access to all official and medical documents. You also agree that the insurance company forwards the data relevant for the claims execution to third parties or to involved insurance companies (first insurer, re-insurer) in Switzerland as well as abroad and that it obtains all relevant data from them. The person signing is not allowed to accept any claim for damages without agreement of the company.

Place and date Signature of the employer/policy holder

Please send the form either via e-mail to versicherungen@arisco.ch or per mail to the agency of your account manager. You can find the address at www.arisco.ch/kontakt. Thank you.

PRINT RESET SEND

ARISCO
RISK CONSULTANTS

NOTIFICATION OF DAMAGE 3/5
Accident report UVG – Doctor's certificate

1. EMPLOYER/CONTRACT HOLDER

Name		Company	
Address		Agency	
Telephone		Policy nr.	
E-Mail		Claims nr.	

2. INSURED PERSON

Name/First name		AHV nr./Social security nr.	
Address		Sex	○ Female ○ Male
Postal code/City		Telephone	
Date of birth		E-Mail	

3. DATE OF ACCIDENT AND CONSEQUENCES

Date of the accident _____ Time _____

Affected body part ○ Left ○ Right ○ Not clear

Doctors' adresses

First attending doctor

Completion of treatment (doctor or hospital)

DOCTOR'S REPORT

Doctor's invoice

A. Service according to tariff

Date	Tariff number	Reference number	Number	Taxpoints TARMED AL + TL	Labor	Physio
		Total				

B. Medication / Material

Quantity	Type	CHF
	Total Medication / Material	

Diagnosis (injured body part and nature of injury) — CHF

Treatment concluded ○ Yes ○ No

Remarks

Total TP TARMED x CHF / TP___ = Total TARMED	
Total TP Analysenliste x CHF / TP___ = Total Labor	
Total TP Physio x CHF / TP___ = Total Physio	
Total Medication / Material	
Total amount	

Date	Post/Bank account

Copy to: Insured person → Doctor → UVG insurer

ARISCO
RISK CONSULTANTS

NOTIFICATION OF DAMAGE 4/5
Accident report UVG – Accident certificate

1. EMPLOYER/CONTRACT HOLDER

Name		Company	
Address		Policy nr.	
Telephone		Claims nr.	
E-Mail			

2. INSURED PERSON

Name/First name		AHV nr./Social security nr.	
Address		Date of birth	
Postal code/City		Sex	○ Female ○ Male
Telephone		E-Mail	

3. DATE OF ACCIDENT

Date of accident		Time	

Information for the insured person
We ask you to always mention the claims number on the accident certificate and the pharmacist's certificate. The claims number is mentioned on any correspondence of the insurance company. The accident certificate remains with you until you are fully recovered. It is to be handed over to the doctor for any consultation and after the treatment it has to be handed in to the employer. This certificate does not qualify as an acceptance of liability. In case you change the doctor please contact immediately the insurance company. Hospital treatment: The accident insurance according UVG takes over all cost in the general ward. For the length of the hospitalisation a contribution to the running costs can be deducted from the daily indemnity. Such restrictions do not apply in case of an eventual UVG-Z insurance. An incapacity to work will be mentioned by the doctor on the accident certificate. Part-time workers have to meet the full working hours unless the doctor prescribes something else for medical reasons (see the box below left). A right to a daily indemnity from the accident insurance according UVG begins on the 3rd calendar day after the accident. The daily indemnity amounts to 80% of the insured salary. The message, given to you when accepting the claim, provides you with the relevant details. The necessary travel and transport costs will be reimbursed to you. Please use an adequate, well-priced means of transportation (e.g. public transport) under consideration of the circumstances.

Doctor's entries

Date		Incapability to work		Doctor's signature
and time of the next consultation	of the last consultation	Degree	Valid	
* Possibly comments on partial workability				
1) % i.e.	hours/day to	%		
2) % i.e.	hours/day to	%		
3) % i.e.	hours/day to	%		

Date		Incapability to work		Doctor's signature
and time of the next consultation	of the last consultation	Degree	Valid	
The medical treatment was completed on...				
Doctor's stamp				

Copy to: Insured person → Employer → UVG-Insurer

ARISCO
RISK CONSULTANTS

NOTIFICATION OF DAMAGE 5/5
Accident report UVG – Pharmacist's certificate

1. EMPLOYER/CONTRACT HOLDER

Name		Company	
Address		Postal/Bank details	
Telephone		Policy nr.	
E-Mail		Claims nr.	

2. INSURED PERSON

Name/First name		AHV nr./Social security nr.	
Address		Date of birth	
Postal code/City		Sex	○ Female ○ Male
Telephone		E-Mail	

3. DATE OF ACCIDENT

Date of Accident | Time

Notes for the insured person
Medication prescribed by your doctor will be provided by a pharmacist at no charge. Obtain all medication from the same pharmacist.

Note for the pharmacist
Please send this invoice following completion of the treatment to the address mentioned below. You can request a new pharmacist's certificate if:

- there is insufficent space to enter the items obtained
- additional medication is required after 3 months

PHARMACIST'S REPORT

Pharmacy invoice

Date of supply	Type and quantity	Price CHF
Please enclose prescriptions	Total amount	

By signing this document you empower the insurance company to get access to all official and medical documents. You also agree that the insurance company forwards the data relevant for the claims execution to third parties or to involved insurance companies (first insurer, reinsurer) in Switzerland as well as abroad and that it obtains all relevant data from them. The person signing is not allowed to accept any claim for damages without agreement of the company.

Date

Pharmacist's stamp

Postal/Bank details

Copy to: Insured person ⟶ Pharmacist ⟶ UVG-insurer