ARISCO
RISK CONSULTANTS

NOTIFICATION OF DAMAGE 1/4
Minor Accident report UVG

1. EMPLOYER/CONTRACT HOLDER

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

2. INSURED PERSON

Name/First name		Hometown/Nationality	
Address		AHV nr./Social security nr.	
Postal code/City		Sex	○ Female ○ Male
Telephone		Marital status	please choose...
Date of birth		E-mail	

Number of children below 18 or in education

3. OCCUPATION IN THE COMPANY

Normal occupation | Date of employment

Position ○ Higher management ○ Middle management ○ Employer ○ Apprentice

Insured's working hours/week

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

Normal full working hours

4. DESCRIPTION OF THE ACCIDENT

Date of accident | Time

Place of accident

Description of the accident

Occupational accident: Objects involved (i.e. machines, tools, vehicles, materials; exact description please)

Non-occupational accident: when did the insured person last work in the company prior to the accident (day, date, time)?

Until | Reason for absence

NOTIFICATION OF DAMAGE 2/4
Minor Accident report UVG

5. CONSEQUENCES OF THE ACCIDENT

Affected body part		○ Left	○ Right	○ Not clear	
Type of impairment					
First attending doctor					
Completion of treatment (doctor or hospital)					
Was the accident reported by the police?	○ Yes ○ No	Report written 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.					

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, 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.

Place and date | Signature of the employer/policy holder

Information for the employer
This minor accident report UVG has to be completed if the injury does not result in any incapacity to work or if the incapacity to work does not exceed a maximum of 3 calendar days (date of the accident plus the two following days). Exceptions: in the following cases the Accident report UVG has to be completed instead of this minor accident report: occupational illness, dental impairment or relapse. If any other doctor(s) are consulted, we will send him/them an invoice form. For reimbursement claims of bills, which have already been paid, please include documents and then the payment location (postal/bank account).

Copy to: UVG-insurer

Please send the form either via e-mail to schaden@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 3/4
Doctor's report

1. EMPLOYER/POLICY 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 AND CONSEQUENCES

Date of accident		Time	
Affected body part		○ Left ○ Right ○ Not clear	
First attending doctor			
Completion of treatment (doctor or hospital)			

DOCTOR'S REPORT

Doctor's invoice

A. Services according to tariff

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

B. Medication/Material

Quantity	Type	CHF
	Total Medication/Material	

Diagnosis (injured body part and nature of injury)	CHF
	Total TP TARMED x CHF/TP___ = Total TARMED
Treatment concluded ○ Yes ○ No	Total TP Analysenliste x CHF/TP___ = Total Labor
	Total TP Physio x CHF/TP___ = Total Physio
Remarks	Total medication/Material
	Total amount

Date	Postal/Bank details

Copy to: First attending doctor → UVG-insurer

NOTIFICATION OF DAMAGE 4/4
Minor Accident report UVG – Pharmacist's certificate

1. EMPLOYER/POLICY HOLD

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 THE ACCIDENT

Date of the accident | Time | Hour

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 – no later than 3 months after the accident. You can request a new pharmacist's certificate, if:

– there is insufficient 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	
			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
Please enclose prescription		Total	

Copy to: Insured person ⟶ Pharmacist ⟶ UVG-insurer