ARISCO
RISK CONSULTANTS

NOTIFICATION OF DAMAGE 1/3
Sickness benefit insurance

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

2. INSURED PERSON

Personal-Number		AHV nr./Social security nr.	
Name/First name		Sex	○ Female ○ Male
Postal code/City		Address	
Date of birth		Telephone/Mobile	
Hometown/Nationality		Mother tongue	
Liable to tax deducted at source	○ Yes ○ No	E-mail	
If yes, central register for foreigners (ZAR)		Marital status	please choose...

3. OCCUPATION

Date of employment ○ Unlimited ○ Limited ○ Employment contract has been terminated per

Normal occupation | Vocation learned

Short description of the normal profession activity

Position ◉ Higher management ○ Middle management ○ Employer ○ Apprentice

○ Temporary help as

Workplace abroad ○ Yes ○ No

Usual workplace

Percentage distribution % standing up % alternating % sitting

Strain of the body ○ Heavy ○ Medium ○ Light

Does the activity strain ○ Back ○ Shoulders ○ No strain of back and/or shoulders

Weights over 10 kg must be lifted regularly ○ No ○ Yes – ca. times per day

4. DISEASE DATA

Date incapacity started | Expected duration

Cause ○ Illness ○ Maternity ○ Accident occupational illness

Has the patient suffered from the same illness before? ○ No ○ Yes – when?

Type of suffering

Doctor's address

First attending doctor

Completion of treatment (doctor or hospital)

Absences during the last 12 months caused by illness

Up to 1 week times | up to 2 weeks times | longer than 2 weeks times

Remarks

Are holidays abroad planned? ○ No ○ Yes – from date - until date

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NOTIFICATION OF DAMAGE 2/3
Sickness benefit insurance

5. SALARY INFORMATION

The insured person has left work	at (data)	at (time)
The insured person has come back to work	Part-time %	at at hour
Weekly working time of the insured	Hours per week	☐ Irregular
	Days per week	☐ Irregular
		☐ Short-time work
Contractual employment level	%	
Normal company working hours	Hours per week	

Salary CHF	per hour	per month	per year
Base salary incl. indexation (gross)			
Children allowance/Family allowance in % or CHF			
Compensation for holidays/public holidays			
Gratuity/13 monthly salary (and others) in % or CHF			
Other salary allowances (commission/			
Payment per kind/shift premium) - What?			

The daily allowance is to be paid to	○ Company	○ Insured person
	○ Post account	
	○ Bank account	
	Bank address	

Other insurance benefits

Is the insured person already entitled to daily allowances or retirement pensions by means of: health insurance, SUVA or other obligatory accident insurance, disability insurance, old age and survivor's insurance, military insurance, unemployment.

○ No ○ Yes – at which insurance?

Which insurance company covers the healing cost for the insured person?

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

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 3/3
Sickness benefit insurance – Daily allowance card

CONTROL CARD FOR CLARITY INCAPACITY

7. EMPLOYER/CONTRACT HOLDER

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

8. INSURED PERSON

Personal number		AHV nr.	
Name/First name		Sex	○ Female ○ Male
Postal code/City		Address	
Date of birth		Telephone/Mobile	
Hometown/Nationality		Mother tongue	
Liable to tax deducted at source	○ Yes ○ No	E-mail	
If yes, central register for foreigners (ZAR)		Marital status	please choose...

Information for the insured person
The control card (daily allowance card) remains with the insured person and is to be presented to the doctor for entry of the incapacity to work. The control card has to be presented to the doctor upon any visit to confirm the incapacity to work. In order to calculate your entitlement the control card has to be handed in to the insurer on a monthly basis. Upon termination of the incapacity to work the original control card has to be sent to the insurer. By signing this document you entitle the insurer to request all necessary information from the doctors who treat you or who have treated you earlier. Also you entitle the insurer to obtain Information from the flies of the compulsory accident insurance (UVG), the disability insurance IV and other insurances or health insurance companies. The insurer will provide you with your benefits under the caveat of an offsetting of potential benefits of the disability insurer (direct right to return).

Place and date

Signature of the employer/policy holder

9. DOCTOR'S ENTRIES

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

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

Copy to: Insured person ⟶ Employer ⟶ Insurer

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