



Sympany Insurance Ltd.

Peter Merian-Weg 4
 4002 Basel
 Phone 0800 955 000
 Fax 0800 955 999
 www.sympany.ch

Notification of illness/Notification of maternity

1. Employer

	Name and address with postal code	Tel. No. _____	Policy No. _____
		Contact (name, telephone number, e-mail)	

		Normal workplace of the sick person (branch of business)	

2. Sick person

	Name and address with postal code	Date of birth	AHV number
		Tel. No. (if known)	Citizenship
	<input type="checkbox"/> Liable to withholding tax	Children up to the age of 18 or in training up to age of 25 (number)	Marital status
	<input type="checkbox"/> Male <input type="checkbox"/> Female		

3. Employment

	Date of appointment	Occupation practised	Group/Circle of persons
	Position: <input type="checkbox"/> Higher executive management <input type="checkbox"/> Intermediate management <input type="checkbox"/> Salaried employee/worker <input type="checkbox"/> Apprentice <input type="checkbox"/> Trainee		
	Relationship: <input type="checkbox"/> Unlimited employment contract <input type="checkbox"/> Fixed-term employment contract <input type="checkbox"/> Employment relationship under notice		
	Working time of sick person (hours per week):	Days per week:	
	Usual company full working time (hours per week):	Assignment:	

4. Event Illness Maternity Date of illness/Expected date of birth: _____

5. Incapacity to work

Work interrupted as a result of illness/maternity? Yes No If yes, from when? _____

Probable duration: _____ If work has been resumed again: _____
 From when? _____

6. Physicians' addresses

First physician or hospital/clinic giving treatment	Physician or hospital/clinic giving follow-up treatment
_____	_____
_____	_____

7. Wage

	CHF per	hour	month	year
Contractual basic wage including cost-of-living allowance (gross)				
Child/Family allowances				
Vacation/Public holiday pay				
Gratuity/13 th month's wage and further				
Other wage bonuses (e.g. piece-work/commission/remuneration in kind/shift allowance)				
Designation: _____				

8. The daily allowance payment is to be remitted to the following PostFinance or Bank account:

Account holder's name	_____
Bank account	Bank's name and location
PostFinance	Clearing No./bank's PC account
	Account No.

9. Other insurances

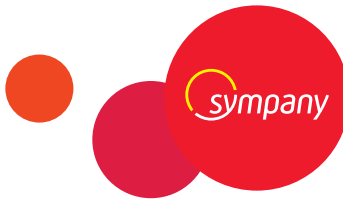
Has the insured already right to a daily allowance or pension from: health insurance, Suva or other mandatory accident insurance, disability insurance, retirement and surviving dependants' insurance, occupational pension institution, military insurance, unemployment fund or to maternity allowance? If yes, where?

10. Observation to the insurance



Place and date _____

Stamp and signature _____



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Medical certificate

Sympany Insurance is obliged to maintain secrecy on the diagnosis!

1. Employer	Name and address with postal code		Tel. No. _____ Policy No. _____	
	_____		Contact (name, telephone number, e-mail)	
2. Insured person	Name and address with postal code		Date of birth	AHV number
	_____		_____	_____
	_____		Tel. No. (if known)	Citizenship
	<input type="checkbox"/> Liable to withholding tax <input type="checkbox"/> Male <input type="checkbox"/> Female		Children up to the age of 18 or in training up to age of 25 (number)	Marital status
3. Diagnosis	<input type="checkbox"/> Illness <input type="checkbox"/> Occupational illness <input type="checkbox"/> Maternity <input type="checkbox"/> Accident		ICD Code: _____	

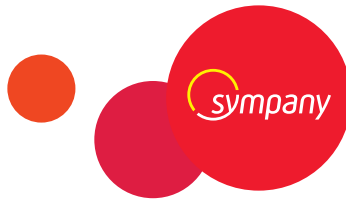
4. Prognosis	_____			
5. Beginning of symptoms	_____			
6. Beginning of treatment	Date	_____	Did the complaint exist already earlier? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, since when?	_____		
7. Incapacity to work	<input type="checkbox"/> Complete incapacity to work	from _____	till _____	at _____ %
	<input type="checkbox"/> Partial incapacity to work	from _____	till _____	at _____ %
		from _____	till _____	at _____ %
8. Commencement of work	Probably	<input type="checkbox"/> Yes	as of _____	at _____ %
		<input type="checkbox"/> No		
	Is another, lighter activity acceptable? If yes, what one and from when? (e.g. household, administrative, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
9. Are there doubts about the incapacity to work on your part?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	If yes, what ones?	_____		
10. Should further clarifications be carried out?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	If yes, what ones and by whom?	_____		
11. Have you completed certificates for other insurances?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	If yes, what ones?	_____		
	Has an IV notification been made?	<input type="checkbox"/> Yes/Date _____	<input type="checkbox"/> No	<input type="checkbox"/> For retraining <input type="checkbox"/> For pension
12. Comments	_____			

Place and date _____

Physician's signature and stamp _____

In order that no delay will occur in the daily allowance payments for the insured, we would ask you to please return the completed and signed report within 7 days to Sympany Insurance medical examiner.





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Sickness day check

Employer	Name and address with postal code	Tel. No. _____ Policy No. _____
	_____	Contact (name, telephone number, e-mail) _____
	_____	_____
	_____	Normal workplace of the injured person (branch of business) _____

Insured person	Name and address with postal code	Date of birth _____ AHV number _____
	_____	Tel. No. (if known) _____ Citizenship _____
	_____	Children up to the age of 18 or in training up to age of 25 (number) _____ Marital status _____
	<input type="checkbox"/> Liable to withholding tax	
	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Event	<input type="checkbox"/> Illness <input type="checkbox"/> Maternity	Date of illness/expected date of birth: _____
Incapacity to work	Work interrupted as a result of illness/maternity? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, from when? _____
	Probable duration: _____	If work has been resumed again: _____
		From when? _____

Notes for the sick person

This Certificate of incapacity to work remains in your hands for the period of your recovery; it is to be shown to the physician at every visit and to be handed over to your company at the end of the treatment.
 This certificate shall not be regarded as the acceptance of an obligation to pay benefits. In the case of a possible change of physician, would you please get into contact with the Insurance immediately.

An incapacity to work will be entered in the certificate of incapacity to work by the physician.
 Persons capable of part-time work shall have to observe the full working time, unless the physician directs something to the contrary for medical reasons (see box below left).*

Entries by the physician

Date of the visit made	Degree	Incapacity to work		Physician's signature
		Valid from	until	

* Possible observations on the partial capacity to work
 1) _____ %, i.e. _____ hours/day at _____ %
 2) _____ %, i.e. _____ hours/day at _____ %
 3) _____ %, i.e. _____ hours/day at _____ %

The medical treatment ended on _____

Medicines obtained from (Pharmacy's name and address):

Physician's stamp

Goes to: injured person → Company → Sympany

