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

Accident report UVG

☐ Accident ☐ Dental damage Claim number
☐ Occupational disease ☐ Relapse

1. Employer
Name and address with postal code | Tel. No. | Contract/Policy No.

Contact (name, telephone number, e-mail)

Normal workplace of the injured person (branch of business)

2. Injured person
Name and address with postal code | Date of birth | AHV number

Tel. No. (if known) | Citizenship

☐ Liable to withholding tax
☐ Male ☐ Female
Children up to the age of 18 or undergoing training up to the age of 26 (number) | Marital status

3. Employment
Date of appointment | Occupation practised | Group/Circle of persons

Position: ☐ Higher executive management ☐ Intermediate management ☐ Salaried employee/worker ☐ Apprentice ☐ Trainee
Relationship: ☐ Unlimited employment contract ☐ Fixed-term employment contract ☐ Employment relationship under notice

Working time of the sick person (hours per week):
Usual company full working time (hours per week):
Contractual degree of employment:
Assignment:

4. Claim date
Day Month Year Time (hours, minutes)

5. Scene of accident
Location (name or postal code) and place (e.g. workshop, road)

6. Statement of facts (description of accident, suspicion of occupational illness)
Activity at the time of accident; particulars of accident, persons involved, objects involved, vehicles
Person(s) involved):
Does a police report exist? ☐ Yes ☐ No ☐ Not known

7. Occupational accident
Object involved (e.g. machine, tool, vehicle, working material; exact designation please)

8. Non-occupational accident
Until when did the insured last work in the company before the accident (weekday, date, rime)?
Until: Reason for absence:

9. Injury
Part of body:
☐ Left ☐ Right
Injury:

10. Incapacity to work
Work interrupted as a result of the accident? ☐ Yes ☐ No If yes, from when?
Probable duration of the incapacity to work:
longer than 1 month: ☐
If work has been resumed again:
From when?

11. Physicians' addresses
First physician or hospital/Clinic giving treatment
Physician or hospital/Clinic giving follow-up treatment

12. Wage

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

13. Special cases
☐ Voluntary employer's liability insurance ☐ Family member, partner ☐ Further employer(s):

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

Place and date
Stamp and signature

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Reference number (EAN): 7601003019759

Pharmacist's Certificate UVG

Please note the claim number here — Claim number

Employer — Name and address with postal code — Tel. No. — Contract/Policy No.

Normal place of work of the injured person (branch of business)

Injured person — Name and address with postal code — Date of birth — AHV number

Occupation practised — Contractual degree of employment

☐ Male ☐ Female

Claim date — Day — Month — Year — Time (hours, minutes)

Notes for the injured person

If the insurance has assured you that it will assume the costs of medical treatment, then the medicines prescribed by the physician will be given to you by the pharmacist without payment.

You should obtain all the medicines from the pharmacist to whom this certificate is to be delivered. We would ask you to please enter the claim number given above in all correspondence or to have it entered by the pharmacist.

Notes for the pharmacist

An assumption of the costs of treatment will be announced to the insured person by the insurance. Please ask for this confirmation – which also serves you as a guarantee for payment – for inspection, and enter the claim number shown on it in this Pharmacist's Certificate.

The pharmacy's invoice

Date of the delivery	Type and quantity	Price CHF	Price Ct.

Please enclose prescriptions — Total 0.00

Please send this invoice after completion of the treatment – at the latest, however, 3 months after the date of the accident – to the address shown above.

You can request a new Pharmacist's Certificate from the insurance, quoting the claim number, if

- the space for entering the items obtained is not sufficient
- further medicines are needed after the end of 3 months

Date

Pharmacy's stamp

PostFinance account No., bank and bank account No.

When settling through OFAC: 35-1

Goes to: Insured → Pharmacist → Sympany

Sympany Insurance Ltd.
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Reference number (EAN): 7601003019759

Physician's Certificate UVG

Please note the claim number here — Claim number

1. Employer — Name and address with postal code — Tel. No. — Contract/Policy No.

Normal place of work of the injured person (branch of business)

2. Injured person — Name and address with postal code — Date of birth — AHV number

Occupation practised — Contractual degree of employment

☐ Male ☐ Female

3. Claim date — Day Month Year — Time (hours, minutes)

4. First treatment — Day Month Year Time

☐ During ☐ At scene of accident ☐ Outside of consulting hours ☐ In the patient's dwelling

5. Patient's details — Particulars of accident and complaints, relapse?

6. General state — a) Special observations (emotional state, alcohol, drugs, etc.)

b) Consequences of illnesses and accidents as well as physical anomalies (disability)

7. Findings

X-ray findings

8. Diagnosis

9. Causality — Are only consequences of the accident present? ☐ Yes ☐ No
If no, please substantiate:

10. Therapy — a) What steps have you taken up to now?

b) Do you propose special measures?

c) Has the patient been admitted to hospital? ☐ Yes ☐ No If yes, where?

11. Incapacity to work — Work interrupted as a result of the accident? ☐ Yes ☐ No If yes, from when?
If work has been resumed again ☐ Wholly ☐ Partially From when?

12. Resumption of work — ☐ Yes Partially at % from In full from
☐ No

13. Completion of treatment — ☐ Yes On
☐ No Probably in weeks

Place and date — Physician's signature and stamp

Goes to: First physician/hospital giving treatment

This physician's certificate is to be passed on to Sympany Insurance immediately