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

☐ Liable to withholding tax

☐ Male ☐ Female

Children up to the age of 18 or in training up to age of 25 (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 sick person (hours per week):
Usual company full working time (hours per week):

Days 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/13th 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
PostFinance

Bank's name and location
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

Sympany Insurance Ltd.
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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)

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

2. Insured 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 in training up to age of 25 (number)

Marital status

3. Diagnosis

☐ Illness ☐ Occupational illness ☐ Maternity ☐ Accident ICD Code:

4. Prognosis

5. Beginning of symptoms

6. Beginning of treatment

Date Did the complaint exist already earlier? ☐ Yes ☐ No

If yes, since when?

7. Incapacity to work

☐ Complete incapacity to work from till at %

☐ Partial incapacity to work from till at %

from till at %

8. Commencement of work

Probably ☐ Yes ☐ No as of at %

Is another, lighter activity acceptable? ☐ Yes ☐ No

If yes, what one and from when?
(e.g. household, administrative, etc.)

9. Are there doubts about the incapacity to work on your part? ☐ Yes ☐ No

If yes, what ones?

10. Should further clarifications be carried out? ☐ Yes ☐ No

If yes, what ones and by whom?

11. Have you completed certificates for other insurances? ☐ Yes ☐ No

If yes, what ones?

Has an IV notification been made? ☐ Yes/Date ☐ No ☐ For retraining ☐ 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
☐ Liable to withholding tax
☐ Male ☐ Female
Children up to the age of 18 or in training up to age of 25 (number) Marital status

Event
☐ Illness ☐ Maternity
Date of illness/expected date of birth:

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?

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	Incapacity to work			Physician's signature
	Degree	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

Physician's stamp

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

Goes to: injured person → Company → Sympany