

Sympany Insurance Ltd.

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

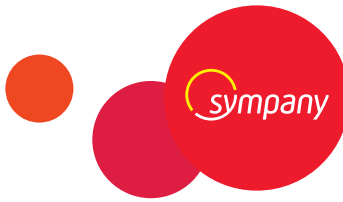
Accident report UVG

		<input type="checkbox"/> Accident	<input type="checkbox"/> Dental damage	Claim number
		<input type="checkbox"/> Occupational disease	<input type="checkbox"/> 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	
	<input type="checkbox"/> Liable to withholding tax	Children up to the age of 18 or undergoing training up to the age of 26 (number)		Marital status
	<input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation practised		
3. Employment	Date of appointment	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 the sick person (hours per week):		Contractual degree of employment:	
	Usual company full working time (hours per week):		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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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, time)?			
	Until: _____	Reason for absence: _____		
9. Injury	Part of body: _____	Injury: _____		
	<input type="checkbox"/> Left <input type="checkbox"/> Right			
10. Incapacity to work	Work interrupted as a result of the accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, from when? _____	
	Probable duration of the incapacity to work: longer than 1 month: <input type="checkbox"/>	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
	Contractual basic wage including cost-of-living allowance (gross)			year
	Child/Family allowance			
	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: _____			
13. Special cases	<input type="checkbox"/> Voluntary employer's liability insurance <input type="checkbox"/> Family member, partner <input type="checkbox"/> 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 _____
	<input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation practised _____	Contractual degree of employment _____
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	Ct.

Please enclose prescriptions Total _____

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 _____

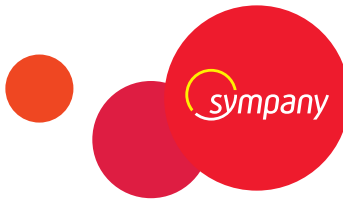
Pharmacy's stamp

PostFinance account No., bank and bank account No.

When settling through OFAC: 35-1

Goes to: Insured → Pharmacist → Sympany





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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
	<input type="checkbox"/> Male <input type="checkbox"/> Female		Occupation practised	Contractual degree of employment
3. Claim date	Day	Month	Year	Time (hours, minutes)
4. First treatment	Day	Month	Year	Time
	<input type="checkbox"/> During <input type="checkbox"/> At scene of accident <input type="checkbox"/> Outside of consulting hours <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?			
11. Incapacity to work	Work interrupted as a result of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, from when?			
	If work has been resumed again <input type="checkbox"/> Wholly <input type="checkbox"/> Partially From when?			
12. Resumption of work	<input type="checkbox"/> Yes <input type="checkbox"/> No	Partially at	% from	In full from
13. Completion of treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	On		
		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

