APPLICATION FOR BENEFITS IN THE EVENT OF DISABILITY

Please have the form **“Medical certificate of incapacity to work”** completed by your attending physician and returned to the following address.

ADDRESS

Generali Personal Insurance Ltd.
Herr Dr. med. Didier Lohner
Abteilung LP-NBC-C
Postfach 1040
8134 Adliswil 1

Please complete and sign **the application form and the power of attorney** and return them to us. Please do not forget to include the enclosures mentioned on the application form.

In particular we ask you to send us a copy of your identification document (including signature).

ADDRESS

Generali Personal Insurance Ltd.
Abteilung LP-NBC-C
Soodmattenstrasse 2
8134 Adliswil 1

Medical certificate of incapacity to work for the attention of the life insurers' consulting doctor

Policy no.:

Start of incapacity to work:

☐ Disease ☐ Accident

1. PATIENT

First name:

Surname:

Date of birth:

Sex:

Address:

2. OCCUPATION

Current occupation(s):

Workload: hours / day hours / day

☐ Employee ☐ Self-employed ☐ Currently not employed

3. TREATMENT

Outpatient treatment with you since? until?

Previous outpatient treatment by (name, address, speciality and duration):

Follow-up outpatient treatment by (name, address, speciality and duration):

Inpatient treatment:

Where?

From when to when?

In the case of surgery, please provide details?

When and where?

4. MEDICAL HISTORY

a) When and how did the disorder first appear?

b) Subjective patient details:

c) Had the patient been treated for this disorder previously? ☐ **Yes** ☐ **No**

If so, where?

When?

d) Previous therapies:

e) Are there any pre-existing illnesses and/or consequences of accidents? ☐ **Yes** ☐ **No**

If so, please provide details:

Since when?

Who was the consulting doctor/hospital?

Are they affecting the healing process? ☐ **Yes** ☐ **No**

If so, to what extent?

5. OBJECTIVE FINDINGS

Examinations, findings of imaging tests, explanations and discharge reports (please provide copies):

Please provide details:

Date?

6. DIAGNOSIS: ICD CODE AND DIFFERENTIAL DIAGNOSIS, IF APPLICABLE:

with an impact on capacity to work

without an impact on capacity to work

Objective restriction on current activities:

7. OTHER FACTORS

Are there any factors that could have a negative impact on the healing process (e.g. working environment, social factors, commute to/from work, addiction)? ☐ **Yes** ☐ **No**

If so, please provide details:

8. THERAPY

a) Current treatment and medication (including dosage):

b) Procedure/suggestions (imaging diagnostics, examination by a specialist doctor, treatments, etc.):

c) Prognosis:

9. INCAPACITY TO WORK

Manageable workload: (% of usual workload):	**Manageable presence at work (hours/day):**	**Incapacity to work as a %:**	**Incapacity to work from:**	**Incapacity to work until:**

Return to work: planned from: ____ at ____ hours/day

expected in: ____ weeks at ____ hours/day

10. REINTEGRATION

a) Is another reasonable job/activity expected to be considered? ☐ **Yes** ☐ **No**

If so, which, and to what extent?

b) Has a new job/activity been started recently? ☐ **Yes** ☐ **No**

If so, please provide details:

c) Are there restrictions in the new job / activity? ☐ **Yes** ☐ **No**

If so, please provide details:

d) From a medical point of view, is there a restriction on driving a vehicle? ☐ **Yes** ☐ **No**

If so, please provide details:

11. CONSULTATIONS

Date of last consultation

Date of next consultation

12. OTHER INSURERS

Are other service providers involved (accident insurers, sickness benefit insurers, invalidity insurance, military insurance, etc.)? ☐ **Yes** ☐ **No**

If so, please provide details:

13. REMARKS

Place and date:

Doctor's address:

Doctor's signatur:

Please return the form to the following address:
Generali Personal Insurance Ltd.
Herr Dr. med. Didier Lohner
Abteilung LP-NBC-C
Postfach 1040
8134 Adliswil 1

APPLICATION FOR BENEFITS IN THE EVENT OF DISABILITY

Generali Personal Insurance Ltd.
New Business & Claims
Soodmattenstrasse 2
Postfach 1040, 8134 Adliswil 1

INSURED PERSON

Policy number(s)	
First name	
Surname	
Date of birth	
Country of birth	
All nationalities	
Address	
E-Mail	
Telephone (home)	
Telephone (work)	
Mobile no.	
AHV-no.	

PAYMENT TO?

Postal or Bank account nr.	
Address / branch	
IBAN	
BIC / SWIFT Code	
Account in the name of (Name and exact adress:)	

Please note that payments to another person than the policyholder are not possible.
Exception: Accounts where the policyholder is one of the two account holders*.

* it this is the case, we also require a copy of the identification document (including the signature) of the second account holder and his / her country of birth and all his / her nationalities

1. A) PROFESSIONAL ACTIVITY

Before occurrence of incapacity to work, employed at (in %)

☐ Employed since | ☐ Self-emloyed since

Employer | Company

No. of employees

Learned occupation

Occupation before occurrence of incapacity to work

1. B) DESCRIPTION OF ACTIVITIES BEFORE OCCURRENCE OF INCAPACITY TO WORK

Physical / manual		in	%
		in	%
Administrative / intellectual		in	%
		in	%
Other		in	%

2. REASON FOR APPLYING FOR BENEFITS (PLEASE USE A SEPERATE SHEET IF YOU WISH TO PROVIDE SUPPLEMENTARY / MORE DETAILLED INFORMATION)

☐ **Accident**

a) Type of injury

b) When was the first medical consultation?

c) Time and place of accident?

d) How did the accident occur?

☐ **Illness**

a) Diagnosis

b) When was the first medical consultation?

c) Progression

d) Beginning

e) Have you previously received treatment for the same illness / accident? ☐ **Yes** ☐ **No**

If yes, from until

Please provide the name / adress of the attending physician at the time

3. ARE YOU UNABLE TO DRIVE A CAR? ☐ Yes ☐ No

4. EXTENT AND DURATION OF INCAPACITY TO WORK

% from to

% from to

% from to

5. MEDICAL TREATMENT

Start of treatment	End of treatment	Attending physicians (if at hospitals, please also give details of department) Names	Addresses

6. OTHER APPLICATIONS FOR BENEFITS

Do you have other insurance cover and / or are other insurance companies handling your claim? If so, which?
Please provide exact addresses of the respective insurance companies and enclose any final statements or decisions

☐ Daily sickness benefits insurance	name:		since	
☐ A state accident insurance institution (e.g.: SUVA in Switzerland)			since	
☐ State military insurance (e.g.: EMV in Switzerland)			since	
☐ State disability insurance (e.g.: IV in Switzerland)			since	
☐ Foreign social insurance	name:		since	
☐ Liability insurance	name:		since	
☐ Life insurance in Switzerland or abroad	name:		since	
☐ Employer's pension fund	name:		since	
☐ Other	type / name:		since	
☐ Other	type / name:		since	

(indicate the exact addresses of the applicable insurances)

Please enclose proofs of income subject to AHV (e.g. salary statements) for the three years prior to occurrence of the incapacity to work and up to the present day.

7. COMMENTS

Please enclose a copy of your identification document (including your signature).

Place, date Signature

POWER OF ATTORNEY

Policy number(s):	
Department:	LP-NBC-C
Insured Person:	

The State Data Protection Act stipulates that a person must be informed of any collection of data with regard to his/her person that is of a particularly sensitive nature. In particular, the purpose for which the data is to be processed must be provided. This personal data may only be processed with the explicit agreement of the person concerned.

Please sign and return this power of attorney so that we can procure the documents necessary to examine and clarify the insured benefits in your case.

Generali Personal Insurance Ltd. undertakes to treat information thus obtained in confidence. As part of the examination of this dossier, particularly in order to clarify the benefits payable, the company is authorised to process the personal data of the undersigned.

The undersigned hereby releases hospitals, physicians, psychologists, therapists; medically trained personnel charged with the medical care/treatment of the insured person and their assistants; health insurance companies, health and accident insurance funds (e.g. the SUVA in Switzerland), state disability insurance (e.g. the IV in Switzerland) and foreign social insurance providers; liability insurance companies, life insurance companies in Switzerland and abroad and employers› pension funds, reinsurers and other third parties (such as employers) **who can provide information in connection with the event that has occurred** from their obligation to maintain professional secrecy or medical confidentiality vis-à-vis Generali Personal Insurance Ltd. and authorises them to give Generali such information and to allow Generali to inspect such files and to receive the information on interim decisions and on the act of disposal that Fortuna requires in order to examine the dossier, particularly in view of clarifying the entitlement to insurance benefits.

I also authorise GENERALI Personenversicherungen AG to forward data and medical documents to the extent necessary to other insurers, reinsurers or expert assessors as well as to procure information from them or third parties.

Place, date Signature