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REPORT OF INCAPACITY FOR WORK (Form for employer)

Page 1 / 2: To be completed by the employer of the person incapacitated for work

COMPANY

Company name _____ P.O. box _____

Contact person _____ Street, No. _____

Tel.-No. _____ Postcode, Place _____

E-Mail _____

INSURED PERSON

Surname, first name _____ OASI No. _____

E-Mail _____ Street, No. _____

Tel.-No. _____ Postcode, Place _____

Date of birth _____ (dd/mm/yyyy) Gender ☐ female ☐ male

Correspondence language ☐ Ge ☐ Fr ☐ It ☐ En

Knowledge of a national language ☐ good ☐ moderate ☐ limited

Civil status ☐ married ☐ registered partnership Married / registered partnership

☐ single ☐ divorced ☐ widowed since _____ (dd/mm/yyyy)

Concubinage ☐ Yes ☐ No

INFORMATION ON INCAPACITY FOR WORK

Date of hire _____ (dd/mm/yyyy) Start of incapacity for work _____ (dd/mm/yyyy)

Enclose a copy of medical certificate (if available)

Degree of employment prior to incapacity for work _____ %

Report / Notification to third-party insurer:

Notification made to		Name of insurance / City
☐ Coll. daily sick leave allowance insurance*	Date: _____	_____
☐ Accident insurance (AIA)*	Date: _____	_____
☐ Disability Insurance	Date: _____	
☐ Federal Military Insurance	Date: _____	

***Enclose copies of the notifications and daily allowance payments**

INFORMATION ON EMPLOYMENT RELATIONSHIP

If the employment relationship has been terminated:

By whom? _____

By what date? _____ (dd/mm/yyyy)

For what reasons? _____

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Page 2 / 2: To be completed by the employer of the person incapacitated for work

INFORMATION ON CASE MANAGEMENT

Is a case manager from another insurer already involved? ☐ Yes ☐ No

If yes, specify insurer and case manager's name _____

_____

Are there alternative job placement options available in your company? ☐ Yes ☐ No

If yes, have they been assessed internally? ☐ Yes ☐ No

Do you wish to receive assistance from PKRück's experts in this regard? ☐ Yes ☐ No

FORWARDING OF DOCUMENTS

To ensure completeness please forward the documents as follows:

Pension institution:	This report form incl. required documents	Forwarding date: _____ (dd/mm/yyyy)
Insured person:	Report of incapacity for work of the insured person	Forwarding date: _____ (dd/mm/yyyy)

COMMENTS

_____

_____

_____

Place, Date: _____ Stamp, signature: _____

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REPORT OF INCAPACITY FOR WORK (Form for pension institution)

Page 3: To be completed by the pension institution

PENSION INSTITUTION (PI)

Name of PI _____ Tel.-No. _____

Contact person _____ E-Mail _____

INFORMATION ON PENSION STATUS

Surname, first name of insured person _____

Date company joined PI _____ (dd/mm/yyyy) Member no. _____

Date insured person joined PI _____ (dd/mm/yyyy) Date insured person left PI (if any) _____ (dd/mm/yyyy)
Enclose a copy of notification

Was a health check performed on joining? ☐ Yes ☐ No If yes:
Enclose a copy of health questionnaire

Was a restriction imposed on joining? ☐ Yes ☐ No If yes:
Enclose a copy of restriction

Was there a disability from a previous pension relationship? ☐ Yes ☐ No If yes, degree of disability? ____ %
Start of entitlement _____ (dd/mm/yyyy)

Have benefits been drawn from your PI due to incapacity for work and/or disability? ☐ Yes ☐ No

COMMENTS

_____

_____

_____

Please note: In a claim event, no payments (early withdrawal under home ownership promotion scheme, pledge, divorce, vested benefits, etc.) may be made. Please implement a corresponding block on payments in your system!

Place, Date: _____ Stamp, signature: _____

Please also enclose the following documents: **Pension certificate, pension plan**

Send this form and the documents to: **PKRück AG, Leistungen, Zollikerstrasse 4, Postfach, 8032 Zürich**

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REPORT OF INCAPACITY FOR WORK

Page 1 / 2: Information for the insured person

Dear Sir or Madam,

We are the reinsurer of your pension institution, which has entrusted us with assessing and managing its claim events. Your employer has informed us that you are (partially) incapacitated for work.

In order for us to assess your claim for exemption from payment of contributions and to calculate any subsequent benefits, we need the following document:

Report of incapacity for work (Form for insured person)
Please complete and sign the form and send it to:
PKRück AG, Leistungen, Zollikerstrasse 4, Postfach, 8032 Zürich

AUTHORISATION AND CONSENT

In the following, we provide you with information on the power of attorney and consent, which you can give us by ticking the box on page 2.

Disclosure of data and authorisation to obtain health data for insurance processing purposes and any checks regarding reported incapacity for work and claim events, and if agreed for the purpose of claim processing. The pension institution has obtained insurance from PKRück AG (www.pkrueck.com) against the risks of death and disability. For insurance processing purposes and to carry out any checks regarding any incapacity for work or claim events reported by the pension institution to PKRück, PKRück needs to be granted full rights to examine your health data and also to obtain further health-related information from third parties. The pension institution may have also instructed PKRück to process the claim events. The pension institution or respectively PKRück will process information relating to your health for the purposes of assessing whether, from when and to what extent you are entitled to occupational benefits. In order to do so, the pension institution or respectively PKRück needs to be granted full rights to examine your health data and also to obtain further health-related information from third parties.

Disclosure of data to reinsurers of PKRück for insurance processing purposes and to carry out any checks regarding the reported claim events. In some cases, PKRück avails itself of further reinsurers. So that such reinsurers can also process the claim and carry out any checks, PKRück will provide your health data to them. Your personal data will be used by the reinsurers only for the above-mentioned purposes.

Should you have any questions, please do not hesitate to contact us by **phone at 044 360 50 70**.

Thank you for your cooperation.

PKRück
Lebensversicherungsgesellschaft
für die betriebliche Vorsorge AG

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REPORT OF INCAPACITY FOR WORK (Form for insured person)

Pension institution _____

INSURED PERSON

Company name _____ Place _____

Surname, first name _____ OASI No. _____

E-Mail _____ Street, No. _____

Tel.-No. _____ Postcode, Place _____

Date of birth _____ (dd/mm/yyyy) Gender ☐ female ☐ male

Correspondence language ☐ Ge ☐ Fr ☐ It ☐ En

Civil status ☐ married ☐ registered partnership ☐ single ☐ divorced ☐ widowed

Married / registered partnership since _____ (dd/mm/yyyy)

Concubinage ☐ Yes* ☐ No *Partner registered with pension institution during lifetime ☐ Yes ☐ No

Education / Profession _____

Short description of your work duties prior to incapacity for work _____

FURTHER INFORMATION

Name of attending physician _____ Adress _____

Is a case manager from another insurer already involved? ☐ Yes ☐ No

If yes, specify name of the insurer and name of the case manager _____

Part-time employees: Are you a part-time employee due to health issues? ☐ Yes ☐ No

Information and inspection of files; authorisation to obtain health data and consent to the disclosure of data

☐ I hereby authorise the pension institution respectively PKRück for the purpose of processing claim events to obtain information verbally and in writing and to request files for inspection from the competent insurers (all social insurers and private insurers) and authorities (including in particular social services, regional employment centres, compensation fund) and from the employer etc. I hereby authorise any physicians, psychologists, physiotherapists, psychotherapists and other medically trained personnel providing treatment to disclose all information and documentation pertaining to my health and any treatment to the pension institution or respectively PKRück for purposes of processing claim events.
I release the above-mentioned persons and any employees of the above-mentioned institutions from their duty of con-fidentiality in respect of the pension institution or respectively PKRück. I further agree that the pension institution or respectively PKRück may pass on my health data to these bodies for the above-mentioned purposes and expressly release the employees of these institutions from their duty of confidentiality.

☐ I hereby consent to the transmission of my health data for insurance processing purposes and to carry out any checks regarding the reported claim events to PKRück and, as the case may be, to any further reinsurers and to its use by them for the purposes specified in this document. This authorisation expressly also covers the right of PKRück to pass on my health data to further reinsurers for the same purposes. I expressly acknowledge and accept that my data, including my health data, may in turn be transmitted by such reinsurers to further reinsurers for the same purposes.

This authorisation granted may be revoked at any time by written notice to the pension institution and to PKRück. The undersigned is aware that the refusal to grant the necessary authorisation or the revocation of any previously granted author-isation may render investigation, insurance processing and thus the provision of occupational benefits impossible.

Place, Date: _____ Signature: _____

Please send the completed form to: **PKRück AG, Leistungen, Zollikerstrasse 4, Postfach, 8032 Zürich**