

Allianz Suisse Life Insurance Company Ltd

Notification of incapacity or inability to work (pension fund/foundation)		Reference	Company name
			Enrolment no. G Policy no.
Insured person	Last name	AHV no.	
	First name	Nationality	
	Address	Residence permit / permanent residence permit	
	Postcode / town (registered where?)	Sex Female <input type="checkbox"/> Male <input type="checkbox"/>	
	Country	Telephone (landline/mobile)	
	Date of birth	Original profession	
	Marital status	Current profession	
Details of employment	Start of employment relationship	Employment relationship under the 6th IV Revision	
	Employment terminated? Yes <input type="checkbox"/> No <input type="checkbox"/> Is so, as of what date?	Notice of termination given by? Employer <input type="checkbox"/> Employee <input type="checkbox"/>	
	Reason for termination?	Self-employed Yes <input type="checkbox"/> No <input type="checkbox"/> Employed Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Insured person's working hours Days per week Hours per week	Normal company working hours (hours per week)	
Details of inability to work	When did the claimant stop work?	Has the claimant since returned to work? If so, when? from to %	
	Expected duration of inability to work Months Days	Pregnancy: birth expected on	
	Nature of illness	Accident: part(s) of the body affected Date of accident:	
Degree of inability to work	% from	% from	
	% from	% from	
	% from	% from	
	% from	% from	
Details of salary	Annual AHV salary (before the claimant stopped working)	CHF	
Other insurance benefits	Is the insured person already entitled to, or has he/she lodged an application for, daily benefits or pension benefits from the state disability insurance scheme (IV), from a daily sickness benefits insurer, from a compulsory accident insurance entity (UVG), from the military insurance or unemployment insurance scheme, or from a private insurer? Yes <input type="checkbox"/> No <input type="checkbox"/> Please provide copies of the corresponding assessments/statements.		
	Daily sickness benefits insurance Contact address		
	Compulsory accident insurance (UVG) Contact address		
	Disability insurance Responsible disability insurance (IV) office		
	Military/unemployment insurance Contact address		
	Private insurer Contact address		
	Place, date		Signature and stamp of employer

Please forward this form (pages 1 and 2) to the insured person for completion.
Even if the employment relationship with the insured person has been terminated, you as an employer still have a duty to provide information. Under the regulations, you are obliged to inform us immediately in writing if the insured person was partially (at least 40%) or totally unable to work for more than 30 days within a period of 90 days beginning on the first day of his/her inability to work.

Power of attorney / details of the insured person	Reference	Company name
		Enrolment no. G Policy no.
Power of attorney / declaration of consent	Power of attorney / declaration of consent	
	For _____, AHV no. _____ <i>Purpose</i> 1. The pension scheme(s) (hereinafter: PS), and Allianz Suisse Life Insurance Company Ltd (hereinafter: ASL) in its capacity as a supporting entity of the PS, are authorized on the basis of this notification to procure, process and pass on data on the insured person, including particularly sensitive personal data and personality profiles, in order to complete their tasks in accordance with the law, the regulations and the group insurance contract. These tasks include, in particular, assessing claims, calculating and granting benefits and coordinating such benefits with those granted, in particular, by other social insurance providers and private insurers, enforcing claims for recourse against liable third parties, promoting the insured person's reintegration into working life, exposing insurance fraud and preventing the unjustified drawing of benefits, and settling claims for benefits together with re-insurers and co-insurers. To assist in executing these tasks, selected third parties may be called upon, who shall process the data only in such a way as the PS and ASL would be permitted to and who shall be subject to the same legal and contractual duty of confidentiality as the PS and ASL. <i>Data acquisition</i> 2. The insured person hereby authorizes the PS and ASL to acquire from public-law and private insurance carriers such as unemployment insurance funds, health insurance funds, private daily sickness benefits insurers, accident insurers, disability insurance (IV) offices, pension funds, doctors and other providers of medical services as well as hospitals and sanatoriums, etc. all of the information and documents that the PS and ASL deem necessary in order to execute the tasks described in paragraph 1 above and, in particular, to inspect the files of the latter (including medical reports and expert opinions). <i>Disclosure of data and inspection of files</i> 3. In individual cases and upon justified written application, the PS and ASL are authorized to disclose all available data on the insured person, including particularly sensitive data and personality profiles, and grant access to the insured person's files to the public-law and private insurance carriers named in paragraph 2 above as well as to social welfare authorities, civil courts, criminal courts and law enforcement authorities, debt enforcement offices, tax authorities, other social insurance institutions, the authorities responsible for collecting withholding tax as well as any other persons granted a legal right to inspect files under statutory pension insurance legislation (BVG). All such information and access to files shall be provided in accordance with the legal provisions and for the purposes described under paragraph 1 above. <i>Passing on of data / allowing inspection of own files</i> 4. Furthermore, the insured person hereby authorizes the PS and ASL to pass on to the responsible disability insurance (IV) office all documents concerning the insured person's inability to work and how it has progressed, also including medical records, in order to increase the insured person's chances of reintegration into working life. If, in addition to official institutions (such as the disability insurance (IV) office), third parties are entrusted with case and/or care management, all necessary documents may be provided to and inspected by them as well. Where necessary, the data may also be passed on to co-insurers and re-insurers for processing. <i>Release from duty of confidentiality</i> 5. Within the scope outlined in paragraphs 1 and 2 above, the insured person hereby releases his/her doctors and other providers of medical services as well as hospitals, sanatoriums, etc. implicitly from all and any duty of confidentiality they bear toward the insured person when providing information to the PS and ASL. Place and date Signature of the insured person or his/her statutory/legal representative	
Details of the insurance relationship since the occurrence of the inability to work	Do you have a new employer? Yes <input type="checkbox"/> No <input type="checkbox"/>	If so, please give the new employer's name and address
	Have you fully regained your ability to work? Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you returned to work in the meantime? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, when? from to %
Doctors treating you for the illnesses in question	Name, address	Name, address
	Name, address	Name, address
3rd pillar	Have you taken out a (pillar-3a or pillar-3b) life insurance policy with Allianz Suisse under which benefits may become payable for the current inability to work? Yes <input type="checkbox"/> No <input type="checkbox"/> If so: policy/claim number	

Please return your completed form to: Allianz Suisse Life, Group Life Claims Service, P.O. Box, 8010 Zurich or to leistungsdienst@allianz-suisse.ch