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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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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:	Form «Authorisation and Consent»	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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POWER OF ATTORNEY AND CONSENT

Your pension provider has reinsured the risks of disability and death with us, PKRück AG (www.pkrueck.com), and has also instructed us, where applicable, to investigate and manage claims. Your employer has informed us that you are (partially) incapacitated for work. In order to clarify and calculate any potential claims for benefits on your part or on the part of your pension provider, we require you to provide us with this power of attorney and consent.

INSURED PERSON

Pension institution _____

Employer _____ Place _____

Surname, first name _____ OASI No. _____

E-Mail _____ Street, No. _____

Tel.-No. _____ Postcode, Place _____

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

Professional activity _____

Treating physician _____ Address _____

In the case of part-time employment: Is the part-time employment due to health reasons? ☐ Yes ☐ No

INFORMATION

1.1 Data forwarding to PKRück and reinsurers for reinsurance purposes/collection of health data for claims processing

a) The pension provider has **reinsured** the risks of disability and death with PKRück AG. For the purposes of risk assessment, claims handling and any necessary verification of reported cases of incapacity for work and claims, PKRück requires the right to review personal data and to obtain further health-related information from third parties. PKRück may engage other reinsurers to carry out these tasks; for this purpose, the necessary personal data, including health data, may be disclosed to them. This data will only be used by the reinsurers for the above-mentioned purposes.

b) If the pension provider has also transferred the **claims for benefits** to PKRück **for processing**, all rights are required to review your personal data and health data, and to obtain further health-related data from third parties in order to assess whether, from when, and to what extent a claim for benefits under the occupational pension plan exists.

1.2 Assessment and offer of reintegration measures (triage/clarification)

The pension provider has commissioned PKRück to offer reintegration measures to individual insured persons following an assessment based on established criteria. In particular, this can help people return to work and support disability prevention. If, following the assessment, an offer is deemed appropriate, PKRück will commission a specialized external agency to contact the insured person (e.g., for an initial consultation).

POWER OF ATTORNEY AND CONSENT

2.1 Consent/power of attorney for clarification, reinsurance and claims processing

a) By signing, I expressly consent to the pension provider transmitting my personal data, including health data, to PKRück for the purposes of risk assessment, insurance processing, and any necessary checks, and potentially transmitting this data to other reinsurers, where it may be processed for the aforementioned purposes. I expressly acknowledge and agree that my data, including health data, will in turn be passed on by these reinsurers to other reinsurers for the same purposes.

b) I hereby authorize the pension provider or PKRück to obtain information verbally or in writing and to request files from social and private insurance providers, government agencies (in particular social services, regional employment offices, and compensation funds), my employer, etc. I hereby authorize any physicians, psychologists, physiotherapists, psychotherapists, and other medical professionals providing treatment to disclose all information and documentation pertaining to my health and any treatment to the pension provider or PKRück for the above-mentioned purposes, and I hereby release them from their duty of confidentiality in this regard. I further agree that employees of the pension provider or PKRück may pass on my personal data and health data required for this purpose to these parties.

2.2 Consent for triage and external implementation of reintegration measures

By signing this document, I expressly consent to the pension provider passing on my personal data, including health data, to PKRück for the purpose of triage/assessment regarding reintegration measures. If an offer is under consideration, my contact information may be shared with a specialized external agency to arrange an initial consultation and, if applicable, to implement the reintegration measures. There is no legal entitlement to reintegration measures.

The powers of attorney and consent granted may be revoked at any time by written notification to the pension provider and PKRück. PLEASE NOTE: Refusal or revocation may make it difficult or impossible to clarify, process insurance, and thus pay occupational pension benefits or implement reintegration measures. If you have any questions, please do not hesitate to contact us on the following telephone number: +41 44 360 50 70

Place, Date: _____ Signature: _____

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