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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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# AUTHORISATION AND CONSENT

Your pension institution has re-insured the risks of invalidity and death with us, PKRück AG (www.pkrueck.com), as well as commissioned us with clarifying and overseeing benefit claims where necessary. According to information from your employer, you are (partially) incapacitated for work. In order to clarify and calculate any claims you or your pension institution may have to benefits, we require the following authorisation and consent from you.

## INSURED PERSON

Pension institution _____

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

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

Name of attending physician _____ Adress _____

_____

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

## INFORMATION

**Data provision to PKRück and any other re-insurers and authorisation to retrieve health data for the purpose of risk assessment, insurance processing and any checks regarding the reported cases of incapacity for work and benefit claims, and for claims processing where agreed.** The pension institution has re-insured the risks of invalidity and death with PKRück AG. For the purpose of risk assessment, insurance processing and any checks regarding the cases of incapacity for work and benefit claims reported by the pension institution to PKRück, PKRück requires all rights to examine your health data and to retrieve further health-related information from third parties. In some cases, PKRück may avail itself of further re-insurers. In order that these re-insurers may also process and, if necessary, check the benefit claim, PKRück shall provide your health data to these parties. Your personal data shall only be used by the re-insurers for the aforementioned purposes. The pension institution may have also assigned the benefit claims to PKRück for processing. The pension institution or PKRück respectively shall process your health-related information to determine whether, from which date and to what extent you may be entitled to a benefit from the occupational pension. To this end, the pension institution or PKRück respectively require all rights to examine your health data and retrieve further health-related information from third parties.

## AUTHORISATION AND CONSENT

**By signing this document, I hereby expressly consent to the pension institution** transmitting my health data for the purpose of risk assessment, insurance processing and occasional checks of the benefit claims reported to PKRück and any further re-insurers, which may be used there for the above-mentioned purposes; I expressly acknowledge and agree that my data, including health data, may in turn be transmitted by these re-insurers on their part to further re-insurers for the same purposes. Moreover, I authorise the pension institution or PKRück respectively to retrieve verbal and written information as well as request documents for inspection from the responsible insurers (all social insurance providers and private insurance providers), authorities (in particular, social services, regional employment centres and compensation funds) and the employer, etc., for the purpose of claims processing. I authorise the physicians, psychologists, physiotherapists, psychotherapists and further medically trained personnel to provide the pension institution or PKRück respectively all information and documents about my health status and any treatments for the purpose of claims processing. I release the aforementioned persons and employees of the above-mentioned institutions from their duty to secrecy towards the pension institution or PKRück respectively. Furthermore, I agree that the pension institution or PKRück respectively may pass on my health data to these parties for the aforementioned purposes and expressly release the employees of these institutions from their duty to secrecy.

**The authorisation and consent provided may be revoked at any time by way of written declaration to the pension institution and PKRück. The undersigned is aware that a refusal to provide the necessary authorisation and consent or a revocation of authorisation and consent provided may render impossible clarification, insurance processing and hence the granting of benefits of occupational pension. Should you have any questions, please contact us on the telephone number 044 360 50 70.**

Place, Date: _____ Signature: _____

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