ARGOS GROUP
Route des Avouillons 30 - 1196 Gland
T +41 22 365 66 64

Notice of Claim UVG Minor

Company / Claim Service / Address

1. Employer	Name		Sinistry No.	
	Address		Contract No.	
	Post code / City		Telephone No.	
	E-mail		Fax No.	

2. Injured	Last name, First name		Civil status	
	Address		Children under 18 years o age or 25 in full-time education	Number
	Post code / City		AVS No.	
	Date of birth	☐ Homme ☐ Femme	Nationality	
	Telephone / Mobile		Permit (B,C,F,G,L,N)	
	E-mail		Subject to income tax at source	☐ yes ☐ no
	CCP / Bank - account		Health insurance	

3. Employment	Usual place of work (sector of company)	☐ operations ☐ technical ☐ office ☐ other	Date of hiring	
	Employed as		Injured persons schedule	(hours per week)
	Length of work contract	☐ permanent ☐ fixed term	Company schedule	(hours per week)
		☐ terminated Date of termination:		
	Function	☐ upper mgmt ☐ middle mgmt ☐ employee ☐ apprentice ☐ intern		
	Occupation	Rate % ☐ regular ☐ irregular	Unemployment	☐ no ☐ partial ☐ total

4. Accident	Date (dd.mm.yyyy)		Time (hh:mm)	

5. Location	Location, place (e.g. workshop)	

6. Facts	Type of accident	☐ accident ☐ dental accident ☐ professional illness ☐ relaps
	Description of accident, suspicion of professional illness Activity at the time of accident, how the accident happened, objects,vehicles that played a part in the accident	

Report	Person(s) involved	
	Police report	☐ yes ☐ no ☐ unknow

8. Non-professional accident	Reason of absence	☐ paid leave ☐ vacation ☐ illness ☐ unpaid ☐ military leave ☐ unemployment ☐ other	Last present at the workplace (date and time	

9. Injury	Part of body affected	☐ Left ☐ Right ☐ Undefined
	Type of injury	

10. Doctor's adresses	Initial care	
	Continuation of treatment	

11. Special cases	Insurance	☐ optional ☐ convention ☐ family member ☐ associate
	Other employers (name, address)	

Information for the Employer

A Notice of Claim UVG Minor must be completed when the injury incurs no loss of working capacity or if this lasts no longer than 3 days maximum (day of the accident and the 2 following days).

If sent by electronic means, the insurance does not require manual signatures

Place andt date:	**Name of signatory:**	**Stamp and signature of employer:**

For : Agent

ACA approved Form

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Form for attending Doctor

1. Employer	Name		Claim No.	
	Address		Contract No.	
	Post code / City		Telephone No.	
	E-mail		Fax No.	

2. Injured	Last name, First name		Civil status	
	Address		Children under 18 years of age or 25 in full-time education	Number
	Post code / City		AVS No.	
	Date of birth	☐ Male ☐ Female		
	Telephone / Mobile			
	E-mail			

3. Employment	Usual place of work sector of company	☐ operation ☐ technical ☐ office ☐ other	Date of hiring	
	Employed as		Injury's schedule	(hours per week)
	Work contract	☐ permanent ☐ fixed term ☐ terminated	Company schedule	(hours per week)
	Fonction	☐ upper mgmt ☐ middle mgmt ☐ employee ☐ apprentice ☐ intern		
	Occupation	Rate % ☐ regular ☐ irregular	Unemployment	☐ no ☐ partial ☐ total

4. Accident	Date (dd.mm.yyyy)		Time (hh:mm)	

Doctor's Notes

5. Diagnostic	Diagnostic Part of the body injured and nature of injury	

7. Treatment	Finished	☐ yes on: ☐ no, probably in weeks

Place et date:	**Stamp and signature of doctor:**

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Notice of Claim UVG Minor

Company / Claim Service / Address

UVG pharmacy sheet

1. Employer	Name		Claim No.	
	Address		Contract No.	
	Post code / City		Telephone No.	
	E-mail		Fax No.	

2. Injured	Last name, First name		
	Address		
	Post code / City		
	Date of birth	☐ Male ☐ Female	
	Telephone / Mobile		
	E-mail		

4. Accident	Date (dd.mm.yyyy)		Time (hh:mm)		

Information for the injured person

When the insurance guarantees their responsibility for treatment costs, the pharmacy will supply medications prescribed by the doctor without requesting payment. Please use the same pharmacy for all your medications. This form must be given to the pharmacy. Please fill in above the claim number that is shown in all our correspondence or ask the pharmacy to fill it in.

Information for the pharmacist

The insurance informs the person injured that they will be responsible for the treatment costs. Please ask to see this notification which is also your guarantee of payment - and fill in the claim number on the pharmacy's form.

Pharmacy Invoice

Date of delivery	Type and quantity	CHF
Please enclose the prescriptions	**TOTAL**	

At the end of treatment, but at the latest 3 months after the date of the accident, please send this invoice to your insurance.

You may request a new pharmacy form from your insurance by mentioning the claim number if the space

- for listing the medications is insufficient
- medication must be supplied after 3 months

Date	
Post CCP / Bank account No.	
OFAC	☐ yes ☐ no
Pharmacy Stamp	

ACA approved Form

Erase | Send to Agent | Print

For: Person insured ▸ Pharmacy ▸ Insurances