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

Notice of Claim UVG

Company / Claim Service / Address

1. Employer	Name		Claim No.	
	Address		Contract No.	
	Post codel / City		Telephon No.	
	E-mail		Fax No.	
	CCP / Bank - account			

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	Nationaly	
	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)	☐ Operation ☐ Technical ☐ Office ☐ Other	Date of hiring	
	Employed as		Party's schedule	(hours per week)
	Length of work contract	☐ undetermined ☐ defined ☐ terminated on	Company schedule	(hours per week)
	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)		Place	

5. Location	Location, place (e.g. workshop)		Was it on the way to work? ☐ Yes ☐ No

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

7. 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 address	Initial care	
	Continuation of treatment	

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

12. Inability to work	Work interrupted	☐ Yes ☐ No If yes from what date ?	Inability to work > 1 month	☐ Yes ☐ No
		Probable length of earning incapacity?		
	Work begun again on		☐ full time ☐ part time	

13. Salary	CHF per	Hourly	Monthly	Yearly
	Base salary (gross, incl. increases)			
	Child/Family allowance			
	Compensation vacation/holidays (% or CHF)			
	Bonus / 13th month salary (% or CHF)			
	Other benefits - type:			

14. Social Insurance benefits	Does the insured already have the right to benefits from a social insurance: Health insurance, UVG insurance, invalidity, old age or survivors, military, unemployment?	☐ Yes ☐ No If yes, which one(s):

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

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

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

Notice of Claim UVG

Company / Claim Service / Address

Medical Report UVG initial

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		Injured person'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)		Place	

5. Initial care	Date (dd.mm.yyyy)		Time (hh:mm)		
	Location	☐ at the scene of the accident ☐ at the patient's home			

6.Patient information	How the accident happened and complaints Relapse ?	
7. General state	Behaviour Antecedents	
8. Observations	General and radiological observations	
9. Diagnostic	Diagnostic	
10. Causality	Are the injuries due only to the accident	☐ Yes ☐ No
	If not, why ?	
11. Therapy	Type of treatment	
	Special measures	
	Hospitalisation	☐ Yes ☐ No If yes hospital:
12. Inability to work	Work interrupted	☐ Yes ☐ No If yes: % since : probably until:
	Work begun	☐ Yes ☐ No If yes: % from the :
13. Treatment	Finished	☐ Yes on: ☐ no, probably in weeks

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

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

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 medication. This form must be given to the pharmacy. Please fill in above the claim number shown in all our correspondence or ask the pharmacy to complete it.

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 complete 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	

For: Person insured ▸ Pharmacy ▸ Insurances

ACA approved Form

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

Company / Claim Service / Address

Claim Form UVG

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)		Place	

Information for the person injured

This report of incapacity to work is to be kept by the person insured. This report must be given to the doctor at each visit.

At the end of the medical treatment, the person insured must give the report to their employer. The latter will then fill in the date of the return to work and send the report promptly to their insurer.

Should the incapacity to work last for more than one month, a copy of this form shall be returned at the end of each additional month to the insurer

Change of doctor. If there is a change of doctor, please immediately contact your insurance.

Hospital treatment Your mandatory accident insurance is responsible for the costs of hospitalisation in the general hospital ward, with reserve for any supplementary UVG coverage. A daily participation in the cost of upkeep (according to OUVG art. 27) is required of patients without children or having no supplementary UVG coverage (max. CHF 20.- for single persons, max. CHF 10.- for married persons).

The right to a daily indemnity arising from the insurance according to the UVG begins on the third day following the accident. Subject to supplementary coverage UVG, the daily indemnity amounts to 80 % of the insured revenue. The communication transmitted to the insured person on acceptation of the accident provides information on the payment of the indemnity.

The costs of necessary travel and transport will be reimbursed. We request that the means of transport chosen should be inexpensive, taking into account the circumstances (e.g.: public transport).

Consultations dates and times			Inability to work		Doctor's signature
	Next	Done	%	As of	
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
Date of the end of medical treatment					
Doctor's stamp					

For: Person insured ▸ Doctor ▸ Person insured ▸ Employer ▸ Insurances

ACA approved Form

Erase | Send to Agent | Print