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

Notice of Claim Health Insurance with loss of revenue

Compagny / Claim Service / Address

Employer	Name	
	Address	
	Post code / City	
	Telephone / Fax	
	E-mail	
	Insurance Contract No.	
	CCP ou bank account	

Personed insured	Last name, First name	
	Address	
	Post code / location	
	Date of birth and gender	☐ Male ☐ Female
	Civil Status	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er)
	AVS No.	
	Private telephone / mobilel	
	E-mail	
	Nationality	
	Work permit (B,C,F,G,L,N)	
	Subject to income tax at source	☐ Yes ☐ No If yes : ZAR n°

Employement Contract	Training and profession	
	Date of hiring	
	If terminated: date of termination	
	If fixed: date of expiry	

Inability to work	Date work was stopped	
	If continuining: date of return of work	Rate of employement %
	Type of ailment	
	Since when the 1st time	
	Last name, first name, address of 1st doctor	
	Is this the result of an accident	☐ Yes ☐ No
	Attending doctot (if different): Name, first name, address	
	Attending doctot (if different): date of 1st consultation	

Weekly work schedule	In days: In hours:	In hours for the compagny
	Occupation:	☐ Regular ☐ Irregular ☐ Partial unemployement ☐ Full unemployement

Salary CHF per	**Hour**	**Day**	**Month**	**Year**
Base salary (gross, incl. increases)				
Piecework / provision				
Allowance children / family				
Compensation vacation / holidays (% or CHF)				
Bonus / 13th month salary (% or CHF)				
Other benefits - type:				
In kind - type:				

Other 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 ones:

ACA approved Form

For : Agent

Place and date:

Stamp and signature of employer:

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Form for inability to work

Person insured	Last name, First name		
	Address		
	Post code / City		
	Date of birth and gender		☐ Male ☐ Female

Claim	Date of accident or illness		Is this the result of an accident ? ☐ Yes ☐ No
	Policy No.		

Doctor	Consultations dates and time		Inability of work		Doctor's signature
	Next	Performed	%	As of	
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
	Date of the end of medical treatment				
Doctor's stamp					

Employer	Name	
	Address	
	Post code / City	
	Insurance Contract No.	
	Date of the insured person's return to work	
	Place and date	
	Signature of the employer	

Information for the personed insured:

This report of incapacity to work is to be kept by the person insured.

This report must be given to the doctor for the completion of section no 3.

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 the insurance.

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

Comments for thDoctor:

Keeping this form up-to-date will allow your insurance to waive intermediary and final medical certificates, subject to specific cases.

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