asga

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Doctor's report on death

Please complete in block capitals. Forms completed in full save you and us extra work.

Deceased

Last name	First name
AHV/AVS no.	Date of birth
Date of death	

1. Cause of death

What was the cause of death?

2. Diagnosis of underlying cause

What underlying cause was diagnosed?

When was it diagnosed?

3. Treatment

Start and duration of your treatment?

4. Treatment by other doctors

Was the deceased also treated by other doctors? ☐ Yes ☐ No

If so, which doctors? (Please give addresses)

▾ *Please pay particular attention to the following page.*

5. Previous illnesses

Which previous illnesses did the deceased have?

Duration?

6. Death by accident

Was the death due to an accident? ☐ Yes ☐ No

If yes, please state type of accident

7. Suicide

Did the deceased commit suicide? ☐ Yes ☐ No

If so, please state type of suicide

Remarks

Place Date

Doctor's stamp and signature

Please enclose the invoice (reimbursements cannot be paid without an invoice) and a paying-in slip, and send them to the following address:

Asga Pensionskasse, Medizinischer Dienst / VB, Rosenbergstrasse 16, 9001 St. Gallen

Invoice amount: CHF

Paid on:

▸ Please send us this form filled out and signed to
Asga Pensionskasse, Medizinischer Dienst / VB, Rosenbergstrasse 16, 9001 St.Gallen.