asga

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Collective Termination Notice

Please fill out in capitalised letters. Completely filled out forms will save you and us extra work.

1. Company

Name

Member/contract no.

2. Insured Persons

Last name/first name	Social security no.	Birth date	Termination date	Street, no.	ZIP Code	City
1.)						
2.)						
3.)						
4.)						
5.)						
6.)						
7.)						

If an insured person is not fully able to work due to illness or accident at the time of employment termination, we kindly ask you to indicate this here:

Place

Date

Stamp and signature of the company

▸ *Please send us this form filled out and signed to Asga, Postfach, 9001 St.Gallen.*