

Notification of incapacity for work

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

Pensionskasse (pension fund) Vorsorgestiftung (pension foundation)

Information on benefit cases

► Waiting period for contribution waiver in accordance with contract.

1. Company name

Name

Member/contract no.

Contact person

Company name Broker

E-mail

Tel. no.

2. Insured

Last name

First name

Social security number

Marital status

Date of birth

Gender

M F

Street, no.

Postcode

Place

E-mail

Tel. no.

Language

GE FR IT EN

Current occupation

3. Insured case

Cause

Accident

Sickness

Pregnancy

No sickness benefits insurance

No sickness benefits insurance

Diagnosis:

Diagnosis:

Occupational disability since (date)

Name of daily sickness benefits provider

Address

Reference no.

Name of contact person

Tel. no.



▼ Please pay particular attention to the following page.

Employment

Degree of employment before incapacity for work set in

- Employment is continuing
- Employment was terminated as of

i *If your employment has been terminated, please send us your notice of termination separately.*

Remarks

Power of attorney

Please send us the signed power of attorney from your employer. By sending us the power of attorney, you will help us process your case as quickly as possible. Please let us know if you would like Asga to obtain the power of attorney subsequently.

- Signed power of attorney attached
- Asga is to obtain the power of attorney subsequently (processing time depends on receipt of power of attorney)

i *Please attach the following documents to this form:*

- ▶ *Copies of the accident or sickness report*
- ▶ *Copies of any benefit and daily sickness benefit statements from insurance policies (AIA, KTG, etc.)*
- ▶ *Doctor's certificate if there is no health insurer*
- ▶ *Power of attorney from the insured*

Place

Date

Stamp and signature of company



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

Power of attorney/authorization

Please complete in BLOCK CAPITALS.

1. Company

Last name

Member/contract no.

2. Insured person

Last name

First name

Social insurance no.

Date of birth

Gender

M F

Street, no.

Postcode

Place

3. Event

Beginning of incapacity for work

Reason

Sickness

Accident

Pregnancy

Name and address of daily allowance insurer

Reference no.

If applic. Contact person

Consulting doctor (name and address)

Note:

- ▶ Please fill in the power of attorney completely. If it is incomplete and if we are unable to obtain all the necessary information, we will assess the case on the basis of the documents in our possession, which may result in a delayed or disadvantageous decision for you.

4. Data processing

Asga (Asga Pensionskasse/Asga Vorsorgestiftung), which operates in Switzerland, is hereby authorized to process data.

The undersigned consents to Asga processing all the necessary information: in connection with assessing the entitlement to benefits, processing the benefits, assessing and implementing the claim to recourse, and reintegration into the workplace.

▼ Please note the following page.



5. Obtaining information

In order to clarify its obligation to pay benefits, Asga is authorized to obtain information and documents about the event in question from the above-mentioned daily allowance insurer and from the above-mentioned doctor and their staff.

6. Release from duty of confidentiality

The above-mentioned persons and institutions are released from their duty of confidentiality.

7. Forwarding of own files

The undersigned also authorizes Asga to forward documents, in particular medical documents, detailing the development of the incapacity for work to the relevant health/accident insurance and the IV/AI office with a view to increasing the chance of reintegrating the person into the workplace. This procedure, however, does not replace the registration with the health/accident insurance and IV/AI, which is the responsibility of the insured themselves.

8. No automatic exchange of data

No automatic exchange of data will take place. Asga is not obliged to engage in clarifications with third parties in each case or to forward information on its own initiative. This also applies within Asga. Data will only be forwarded when appropriate for the purpose and upon specific request.

9. Truthful information

This authorization does not release the undersigned from the obligation to provide truthful and complete information. Likewise, this consent does not release them from the obligation of duly registering the entitlement to benefits with the relevant institutions.

10. Time limit

This power of attorney/authorization applies only for the event listed in point 3.

11. Confidentiality

Asga undertakes to treat this information as confidential and to use it only for the relevant purpose.

12. Form of transmission/exchange of information via e-mail

E-mails are usually sent via data networks that are hard to control. There is therefore a risk that unauthorized persons may see the exchanged information and the e-mail address of the sender and may be able to change them. The undersigned is aware of the risks of e-mail traffic. They expressly consent to Asga transmitting information via e-mail with them and other involved third parties, as set out under "Obtaining information". You can find information on data protection on our website www.asga.ch/datenschutz

Place

Date



Signature of insured or their legal/appointed representative

► Please complete and sign this form and return it with the necessary documents to Asga, Rosenbergstrasse 16, 9001 St. Gallen.