

Illness and Accident Notification Individual Life (Pillars 3a and 3b) in cases of incapacity to work or disability and invalidity

Policy No.

1. Policyholder

Last name/First name

Street/No.

Postal code, City/Town

Phone No.

2. Insured person

Mr. Ms. Mrs.

Last name/First name

Date of birth: Day Month Year

Street/No.

Nationality

Postal code, City/Town

3. Incident

Accident

Illness

4. Date of accident/date of illness

Day Month Year

5. Accident

Accident location

Where did the accident take place? (location, place)

Description of accident

Activity at the time of the accident; circumstances of the accident, persons, machines, equipment, vehicles, materials involved

6. Incapacity to work

When was work stopped?

Date: Day Month Year

If work has been resumed again, then

completely

Date: Day Month Year

partially, to %

Date: Day Month Year

7. Other insurance institutions (IV, Accident Insurance Institution, military insurance, health insurers, private insurers, pension funds etc.)

Are other insurance institutions involved in the same incident? Yes No

If so, which ones? (name, address and reference)

Does the insured person receive a daily allowance or a pension? Yes No

If so, from whom? (name, address and reference)

8. Occupation

Employee? Yes No Self-employed? Yes No

Without occupation? Yes No Unemployed? Yes No

Last occupation

Location

Date: Day Month Year

Please send this form directly to: Zurich Switzerland, Individual Life Benefits, P.O. Box, 8085 Zurich
or by E-Mail to: Einzelleben.SLE@zurich.ch