ZURICH

Incapacity to work/ premium waiver notification Individual Life

(Pillars 3a and 3b)

1 Policy No.

2 Insured person

Mr. Mrs./Ms.

Last name	Date of birth (Day/Month/Year)
First name	Street/No.
Postal Code	City/Town
Phone	Email

Contact details of policy holder if not identical with insured person

3 Disability/Invalidity

Incident: Illness Accident

Work stopped (Day/Month/Year)

Work was resumed on (Day/Month/Year) to

Occupation Details

Employee self-employed Without occupation Unemployed

Last occupation to %

PTO

4 Medical treatment

Initial treatment (doctor)

Further treatment (specialist)

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

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

If so, which ones?

Name, address and reference

6 Remarks

7

Place and Date (Day/Month/Year)

Signature

Please send this form directly to: Zurich Switzerland, Individual Life Benefits, P. O. Box, 8085 Zurich
or by email to: **einzelleben.sle@zurich.ch**

Zurich Company Ltd. is authorized to carry out all transactions on behalf and for the account of Zurich Life Insurance Company Ltd.

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