Baloise Insurances, Service Centre

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Baloise Insurances

LAI Claim

☐ Accident ☐ Dental claim
☐ Occup dissease ☐ Relapse

Claim no.

1. Employer	Name and address with postal code	Phone number	Contract-Nr.
		Normal workplace of the injured person (branch of business)	
2. Injured person	Name	Date of birth	AHV number
	addresse	Phone Nr. (if known)	Nationality
	Postal code	Martial status	Children uf to the age of 18 or in education up to the age of 25 _____ Number ☐ None
3. Employment	Date of employment	Profession carried out	

Position: ☐ Senior management ☐ middle management ☐ Employee/worker ☐ Apprentice ☐ Trainee
Ratio: ☐ Unlimited contract of employment ☐ Limited contract of employment ☐ Terminated contract of employment

Injured person's working hours: (weekly hours) _____ Contractual degree of employment: _____ Prozent
Standard full working hours at the company (weekly hours) _____ Area of work: ☐ irregular ☐ short-time work

4. Date of claim	**Day**	**Month**	**Year**	**Time (HH, MM)**

5. Place of accident — Town (name or postcode) and location (e.g. workshop, road)

6. facts (Description of accident, suspicion of occupational disease) — Activity at the time of the accident; how the accident happened, persons involved, objects involved, vehicles

Person(s) involved:
Does a police report exist? ☐ Yes ☐ No ☐ unknown

7. Occupatio-nal accident — Objects involved (e.g. machine, tool, vehicle, material; please describe exactly)

8. Non-occup. accident — Until when did the injured person last work in the company before the accident (weekday, date, time)?
until: Reason for absence:

9. Injury — Body part: ☐ left ☐ right ☐ unknown
Injury:

10. Disability — Stopped work as a consequence of the accident? ☐ Yes ☐ No If, yes, from when?
Anticipated duration of working incapacity: longer than 1 month ☐
In case work was resumed: From? ☐ full-time ☐ partially

11. Address of medical practitioner — First treatment (doctor and/or hospital/clinic) | Subsequently treatment (doctor and/or hospital/clinic)

12. Salary

	CHF per	Hour	Month	Year
Basic contractual salary incl. Inflation allowance (gross)				
Child/family allowance				
Holiday/public holiday compensation	in % or			
Gratification/13th monthly wage (and others)	in % or			
Other salary allowances (e.g. piece rates, commission, payment in kind, shift allowance)				

Designation:

13. Special cases — ☐ Voluntary insurance for entrepreneurs ☐ Family members, partner ☐ liable to withholding tax
☐ other employer(s):

14. Other social insurance benefits — Can the insuree already claim daily benefits or a pension form: health insurance, Suva or other compulsory accident insurance, old age and survivors insurance (AHV), professional provident institution, military insurance, unemployment fund?
If so, where?
Name of the compulsory health insurance**:**

Place and date Stamp and signature

220.1086e 09.10 300

Baloise Insurance Ltd, Claims Switzerland, Aeschengraben 21, P.O. Box, 4002 Basel
Phone 00800 24 800 800, Fax +41 58 285 90 73, schaden@baloise.ch, www.baloise.ch

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Baloise Insurances

LAI Claim

in duplicate for the employer

☐ Accident ☐ **Dental claim**
☐ **Occup dissease** ☐ **Relapse**

Claim no.

1. Employer	Name and address with postal code	Phone number	Contract-Nr.
		Normal workplace of the injured person (branch of business)	
2. Injured person	Name	Date of birth	AHV number
	addresse	Phone Nr. (if known)	Nationality
	Postal code	Martial status	Children uf to the age of 18 or in education up to the age of 25 _____ Number ☐ None
3. Employment	Date of employment	Profession carried out	

Position: ☐ Senior management ☐ middle management ☐ Employee/worker ☐ Apprentice ☐ Trainee
Ratio: ☐ Unlimited contract of employment ☐ Limited contract of employment ☐ Terminated contract of employment

Injured person's working hours: (weekly hours) _____
Standard full working hours at the company (weekly hours) _____
Contractual degree of employment: _____ Prozent
Area of work: ☐ irregular ☐ short-time work

4. Date of claim	**Day**	**Month**	**Year**	**Time (HH, MM)**

5. Place of accident Town (name or postcode) and location (e.g. workshop, road)

6. facts (Description of accident, suspicion of occupational disease) Activity at the time of the accident; how the accident happened, persons involved, objects involved, vehicles

Person(s) involved:
Does a police report exist? ☐ Yes ☐ No ☐ unknown

7. Occupatio-nal accident Objects involved (e.g. machine, tool, vehicle, material; please describe exactly)

8. Non-occup. accident Until when did the injured person last work in the company before the accident (weekday, date, time)?
until: Reason for absence:

9. Injury Body part: ☐ left ☐ right ☐ unknown
Injury:

10. Disability Stopped work as a consequence of the accident? ☐ Yes ☐ No If, yes, from when?
Anticipated duration of working incapacity: longer than 1 month ☐
In case work was resumed: From? ☐ full-time ☐ partially

11. Address of medical practitioner First treatment (doctor and/or hospital/clinic) | Subsequently treatment (doctor and/or hospital/clinic)

12. Salary

	CHF per	**Hour**	**Month**	**Year**
Basic contractual salary incl. Inflation allowance (gross)				
Child/family allowance				
Holiday/public holiday compensation	in % or			
Gratification/13th monthly wage (and others)	in % or			
Other salary allowances (e.g. piece rates, commission, payment in kind, shift allowance)				

Designation:

13. Special cases ☐ Voluntary insurance for entrepreneurs ☐ Family members, partner ☐ liable to withholding tax
☐ other employer(s):

14. Other social insurance benefits Can the insuree already claim daily benefits or a pension form: health insurance, Suva or other compulsory accident insurance, old age and survivors insurance (AHV), professional provident institution, military insurance, unemployment fund?
If so, where?
Name of the compulsory health insurance**:**

Place and date Stamp and signature

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Medical report LAI

Claim no.

Employer	Name and Address with postcode	Phone no.	Contract-Nr.
		Injured person's usuel workplace (branch of business)	
Injured person	Surname and first name	Date of birth	AHV number
	Street	Phone no (if known)	Nationality
	Postcode Place of residence	Marital status	Children up to the age of 18 or in education up to the age of 25 _____ Number ☐ None
Employment	Date of employment	Profession carried out	

Position: ☐ Senior manager ☐ Executive ☐ Employee / Worker ☐ Apprentice ☐ Trainee
Ratio: ☐ Unlimited contract ☐ Limited contract ☐ Terminated contract

Injured person's working hours: (weekly hours) _____ Contractual degree of employment: _____ %
Standard full working hours at the company (weekly hours) _____ Area of work: ☐ Irregular ☐ Short time

Date of injury	**Day**	**Month**	**Year**	**Time (hour, minute)**

1. First teatment	Day Month Year Time	☐ during ☐ ouside consultation-hour ☐ at the place of accident ☐ in the patient's apartment
2. Patient's statement	Circumstances of the accident and complaint, relapse?	
3. General condition	a) Particular perceptions (frame of mind, alcohol, drugs, etc.) b) Sequels of illness and accidents or body anomalies (disablement)	
4. Results	X-ray results:	
5. Current diagnosis		
6. Causality	a) Which are the causes of the current complaint? ☐ Accident ☐ Illness ☐ other: which?	b) Did the patient previously suffer from similar complaint? ☐ no ☐ yes, teatment by
7. Therapy	a) Which type of cure did you prescribe? b) Do you suggest particular medical or non-medical measures? c) Has the patient been hospitalized? ☐ no ☐ yes, where?	
8. Work incapacity	☐ yes, to what extent? % from likely until ☐ no	
9. Work resuming	☐ yes partially at % from full-time from ☐ no	
10. Conclusion of treatment	☐ yes, on the: ☐ no – likely in weeks	

Place and date Stamp and signature **of the physician**

To: primary care physician → Insurance

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Pharmacy certificate LAI

Claim no.			
1. Employer	Name and address with postal code	Phone Nr.	Contract-Nr.
		Normal workplace of the injured person (branch of business)	
2. Injured person	Name	Date of birth	AHV number
	address with postal code	Phone Nr (if known)	
Date of claim	**Day**	**Month**	**Year**	**Time (HH, MM)**

Notes for the injured person

If the insurance company has agreed to pay the medical costs, your pharmacist will give you the medication prescribed by your physician free of charge.

Obtain all medication from the same pharmacist, to whom you should give this certificate. Please enter the claim number above, which is quoted on all correspondence, or let your pharmacist enter it.

Notes for the pharmacist

The injured person will be informed of an assumption of the cost of treatment by the insurance company. Please ask to see this confirmation, which is your guarantee of payment, and transfer the claim number on it to this pharmacy note.

Pharmacy bill

Date of surrender	Type and quantity	Price CHF	Price Ct.
Please enclose prescriptions	**Total**	**0.00**	

Please send this bill on completion of treatment – at the latest, three months after the date of the accident – to the address listed above.

You can obtain a new pharmacy record by specifying the claim no. from the insurance company if
- there is insufficient space for entering the medication obtained:
- additional medication is required after 3 month.

Date:

Stamp pharmacy:

3	Code	

Post office account no. or bank and IBAN.

For settlement via OFAC: 35-1

to: Injured → Pharmacist → Insurance

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LAI accident certificate

Claim no

1. Employer	Name and address with postal code	Phone Nr	Contract-Nr.
		Normal workplace of the injured person (branch of business)	
2. Injured person	Name	Date of birth	AHV number
	Address with postal code	Phone Nr (if known)	Nationality
		Marital status	Children up to the age of 18 or in education up to the age of 25 ____ Number ☐ None
3. Employment	Date of employment	Profession carried out	

Position: ☐ Senior management ☐ Middle management ☐ Employee/worker ☐ Apprentice ☐ Trainee

Ratio: ☐ Unlimited contract of employment ☐ Limited contract of employment ☐ Terminated contract of employment

Injured person's working hours: (weekly hours) _____ Contractual degree of employment: _____ %

Standard full working hours at the company (weekly hours) _____ Area of work: ☐ irregular ☐ short time

Date of claim	**Day**	**Month**	**Year**	**Time (HH, MM)**

Notes for the injured person

Please write the number of the claim, which is mentioned in all correspondence from the insurance company, on the accident and pharmacy note and always mention it when making inquiries.

This accident certificate remains with you throughout your convalescence; please show it whenever you visit your physician and hand it in to your company upon completion of treatment. This certificate does not count as recognition of an obligation for payment to be made.

Please contact your insurance company immediately if you chance your physician.

As mandatory accident insurers, we will assume the costs of a stay in the general ward of a hospital. A contribution towards food an accommodation costs may be deducted from the daily allowance for the duration of the hospital stay.

The physician will declare on the accident certificate whether the patient is unfit for work. Persons who are partially fit for work must work the full number of hours unless, for medical reasons, the physician prescribes otherwise. (see box at bottom left).*

Persons have a right to claim a daily allowance from the third calendar day following the accident. The daily allowance comprises 80% of the insured earnings. Details pertaining to payment can be found in the information issued to each insured when an accident claim is accepted. You will be reimbursed for the necessary travelling expenses – e.g. to the next physician/hospital. Please select a cost-efficient, appropriate method of transport (e.g. public transport). Cancel the subscription, if appropriate. Please specify your bank or postal checking account on the expenses form. If, for personal reasons, you decide to seek external treatment, the insurance company cannot reimburse the additional costs incurred.

Entries by the physician

Date and time of the next visit	Date of the visit effected	Disability Rate	Disability Valid from	Signature of the physician

* If necessary, remarks as to partial capacity to work				
1)	%, i.e.	Hour/day at	%	
2)	%, i.e.	Hour/day at	%	
3)	%, i.e.	Hour/day at	%	

Date and time of the next visit	Date of the visit effected	Disability Rate	Disability Valid from	Signature of the physician

Medical treatment ended on	Medication obtained from: (Name an address of pharmacy)

Stamp physician

to: Injured → Company → Insurance

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