AVENA

Notice of incapacity for work

This form must be submitted once a situation of incapacity for work has lasted beyond the contractual waiting period.

EMPLOYER

Policy No.: .... / .....

Company name: .....

MEMBER

Last name: ..... First name: .....

AVS No.: .... Date of birth: ..... / ..... / .....

Home address: *(street, number)* .....

(POSTAL CODE, TOWN) .....

CHILDREN

Last name	First name	Date of birth (dd/mm/yyyy)
.....	.....	..... / ..... / .....
.....	.....	..... / ..... / .....
.....	.....	..... / ..... / .....
.....	.....	..... / ..... / .....

Please attach a certificate of studies/training for children aged 18 or older.

INCAPACITY FOR WORK

Starting date of the incapacity for work: ..... / ..... / ..... Family allowances: ☐ yes ☐ no

Cause of the incapacity for work: .....

Annual reference salary when the incapacity for work occurred: CHF ..... beginning on: ..... / ..... / .....

DURATION OF THE INCAPACITY FOR WORK

.....% from ..... /..... /..... to ..... /..... / .....

.....% from ..... /..... /..... to ..... /..... / .....

.....% from ..... /..... /..... to ..... /..... / .....

.....% from ..... / ..... / ..... to ..... / ..... / .....

.....% from ..... / ..... / ..... to ..... / ..... / .....

.....% from ..... / ..... / ..... to ..... / ..... / .....

DOCTOR(S)

Name: .....

Address: .....

.....

Name: .....

Address: .....

.....

INSURANCE

1. Has a disability insurance claim been filed? ☐ no ☐ yes
   If so, enclose a copy of the employer questionnaire.

2. a) Accident insurance: Policy No.: .....

   Address: *(Name, street, number)* .....

   (POSTAL CODE, TOWN) .....

   b) Complementary accident insurance (if applicable): Policy No.: .....

   Address: *(Name, street, number)* .....

   (POSTAL CODE, TOWN) .....

3. Health insurance: Policy No.: .....

   Address: *(Name, street, number)* .....

   (Postal code, town) .....

4. Does the member have more than one employer? ☐ no ☐ yes
   If so, provide contact information for the other employer(s):

Name: ..... Name: .....

Address: ..... Address: .....

....

DOCUMENTS TO ENCLOSE

- Authorization signed by the member
- Sickness or accident declaration
- Insurance statements (income replacement, health and/or accident insurance)
- Medical certificates
- Health insurance form or accident insurance form

Place and date: **Employer's stamp and signature:**

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This document is a translation of the original French document. Only the French version is authoritative.

Please return to:

AVENA Fondation BCV 2e pilier
c/o Banque Cantonale Vaudoise
Case postale 300
1001 Lausanne