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:**

....

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

AVENA
Fondation BCV 2e pilier

Authorization for the pension fund reinsurer

EMPLOYER

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

Company name: .....

MEMBER

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

AVS No.: .... Date de naissance : ..... / ..... / .....

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

(POSTAL CODE, TOWN) .....

TERMS OF THE AUTHORIZATION

a) Other insurers

For the purpose of determining the member's rights and examining his/her insurance claims, the undersigned expressly authorizes the reinsurer of the Foundation to obtain the necessary documents from all public and private insurers that are involved in this claim as a health insurance company, income-replacement insurance company, accident insurance company, AI office, pension fund, etc., and to consult the relevant files (such as medical evaluations and reports from other entities like employment counseling services).

b) Doctors and other medical service providers

By virtue of the signature below, the reinsurer of Fondation BCV deuxième pilier, i.e., La Mobilière, is also authorized to obtain information that it considers necessary from doctors and other medical service providers, as well as from hospitals, health clinics, etc. Consequently, doctors and the aforementioned entities are released from their obligation of professional secrecy relative to the reinsurer of Fondation BCV deuxième pilier, i.e., La Mobilière.

c) Provision of its own records

Furthermore, the undersigned authorizes the reinsurer of Fondation BCV deuxième pilier, i.e., La Mobilière, to provide to the member's AI office all documents related to changes in the member's incapacity for work, particularly medical documents, in order to increase the member's chances of resuming employment. However, having completed and filed this form does not release the member from his or her obligation to file a disability claim.

By signing below, the member accepts all points (a through c) of the above authorization.

Place and date:	**Signature of the member or of his/her legal representative**
.....	.....

Please return to:

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