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PKG
PENSIONSKASSE FÜR KMU

Report of unfitness to work (Employer form)

Pages 1 and 2: To be completed by the employer of the person unfit to work

Company

Company name _____ P.O. Box _____

Company No. _____ Street, No. _____

Contact person _____ Postcode, Place _____

E-mail _____ Tel. No. _____

Insured person

Name, First name _____ OASI No. _____

E-mail _____ Street, No. _____

Tel. No. _____ Postcode, Place _____

Date of birth _____ (dd/mm/yyyy) Gender ☐ female ☐ male

Correspondence language ☐ de ☐ fr ☐ it ☐ en

Civil status ☐ married ☐ civil partnership Married / Civil partnership since _____ (dd/mm/yyyy)

☐ single ☐ divorced ☐ widowed

☐ co-habiting* *Partner registered with pension institution ☐ Yes ☐ No

Contact details of any representative: **Enclose representative's authorisation**

Name, First name _____ Street, No. _____

Tel. No. _____ Postcode, Place _____

Spouse/Partner **Enclose copy of family record book**

Name, First name _____ Date of birth _____ (dd/mm/yyyy) Gender ☐ f ☐ m

Children

Name, First name _____ Date of birth _____ (dd/mm/yyyy) Gender ☐ f ☐ m

Name, First name _____ Date of birth _____ (dd/mm/yyyy) Gender ☐ f ☐ m

Name, First name _____ Date of birth _____ (dd/mm/yyyy) Gender ☐ f ☐ m

Details on unfitness to work

Date joined company _____ (dd/mm/yyyy) Begin of unfitness to work (exact date!) _____ dd/mm/yyyy)
Enclose a copy of doctor's certificate (if available)

Level of employment prior to unfitness to work _____% If part-time, give reason ☐ health reasons

☐ commercial reasons

☐ other: _____

Level of employment after partial unfitness to work occurred _____% Annual salary subject to OASI contributions at beginning of unfitness to work CHF _____

Report/Notification to third-party insurer:

Has a report been made to the Federal Disability Insurance Agency (early recognition)? ☐ Yes, on _____ (dd/mm/yyyy) ☐ No

If yes, by whom? _____

Notification made to **Enclose a copy of report**

☐ Coll. Sickness Benefit Insurance Agency* Date of notification: _____ (dd/mm/yyyy)

☐ Liability and accident insurance (LAI)* Date of notification: _____ (dd/mm/yyyy)

☐ Fed. Disability Insurance Agency Date of notification: _____ (dd/mm/yyyy)

☐ Fed. Military Insurance Agency Date of notification: _____ (dd/mm/yyyy)

*** Enclose copies of the notifications and any daily allowance payments**

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Coll. health insurance agency / LAI agency contact:

Name of insurance agency _____ P.O. Box _____

Policy No. _____ Street, No. _____

Postcode, Place _____

Details on employment relationship

If the employment relationship has been terminated: by whom? _____

on what date? on _____ (dd/mm/yyyy)

why? _____

Last actual day of work prior to unfitness to work on _____ (dd/mm/yyyy)

Are you still employing the insured person? ☐ Yes ☐ No

Insured person's vocational training /trade learned _____

Short description of the person's duties before unfitness to work began _____

Type of employment after occurrence of the damage to health _____

from _____ (dd/mm/yyyy)

Details on case management

Is a case manager at another insurance agency already involved? ☐ Yes ☐ No

If yes, which insurance and agency and what is the case manager's name? _____

Are there options for alternative jobs available in your company? ☐ Yes ☐ No

If yes: Have they been looked into by the company? ☐ Yes ☐ No

Are you interested in assistance from the PKRück's experts in this context? ☐ Yes ☐ No

Forwarding of documents

To ensure completeness please forward the documents as follows:

PKG Pensionskasse:	This report form (Pages 1–2) incl. required copies Address: PKG Pensionskasse, Zürichstrasse 16, 6000 Luzern 6	Forwarding date: _____ (dd/mm/yyyy)
Insured person:	letter "Information for the insured person", "General authorisation" and doctor's questionnaire	Forwarding date: _____ (dd/mm/yyyy)

Comments

_____

_____

Place, Date _____ Stamp, Signature _____

Information for the insured person

Dear Sir or Madam,

We are your pension institution's reinsurer. The institution has requested that we clarify and manage its entitlement cases. Your employer has informed us that you are (partially) unfit to work.

In order for us to be able to clarify your claim to exemption from payment of premiums and to be able to calculate any subsequent benefits for you we require the following documents:

- Doctor's questionnaire – please forward the enclosed form to the doctor treating you.
- Authorisation – please complete and sign the form and send it to:
  PKRück AG, Leistungen, Zollikerstrasse 4, Postfach, 8032 Zurich

Should you have any questions please do not hesitate to contact us under the telephone number 044 360 50 70.

Thanking you in advance

Best regards

PKRück
Lebensversicherungsgesellschaft
für die betriebliche Vorsorge AG

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für die betriebliche Vorsorge AG

Zollikerstrasse 4
Postfach
CH-8032 Zürich

Tel. +41 (0)44 360 50 70
Fax +41 (0)44 360 53 50

info@pkrueck.com
www.pkrueck.com

General authorisation

Name of pension institution: PKG Pensionskasse

Person giving authorisation		**Institution accepting authorisation**
First name, Name	_____	PKRück
Date of birth	_____	Lebensversicherungsgesellschaft für
OASI No.	_____	die betriebliche Vorsorge AG
Street	_____	Vaduz
Postcode, Place	_____	

The person giving authorisation authorises the institution accepting authorisation with regard to

Clarification of benefit entitlement within the scope of social insurance and, in particular, occupational insurance

concerning

Information and access to records
To provide and obtain written and verbal information (including the handing over to the insurance institutions and authorities named below of records for inspection); to inspect his/her records at the relevant insurance institutions and authorities (Federal Disability Insurance Agency; liability and accident insurance agency; sickness benefit insurance agency; unemployment insurance agency; employer; PKRück reinsurers) and to hand over third party records (Federal Disability Insurance Agency; liability and accident insurance agency etc.) to PKRück's reinsurers.

Medical confidentiality
To obtain information and doctors' reports compiled by the insured person's doctor and the medical examination services of the private and social insurance agencies, whereby the doctors are released from their obligation to maintain medical confidentiality.

This authorisation shall not expire upon the death of the person giving the authorisation.

_____ _____

Place, Date

Signature of insured person (Person giving authorisation)

Data protection
The institution accepting the authorisation undertakes to use the data entrusted to it solely for the purposes listed in the authorisation and to comply with Switzerland's data protection regulations at all times. It shall only forward this data to contractual partners who undertake to adhere to the same restrictions.

Please send the completed, signed authorisation to:
PKRück AG, Leistungen, Zollikerstrasse 4, Postfach, 8032 Zürich

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Doctor's questionnaire

This form can be filled out online and then printed.
www.pkrueck.com → Downloads → Kundenformulare → Doctor's questionnaire

General details

Name of pension institution PKG Pensionskasse

First name/Name of insured person _____

Date of birth of insured person _____

Address of insured person _____

Employer _____

Excerpt from patient history commencing _____ (dd/mm/yyyy)

Cause of unfitness to work

Diagnosis _____

_____

_____

When did the first related symptoms occur? _____

In the case of an accident:

Date of accident _____ (dd/mm/yyyy) Type of accident _____

Was the accident caused by a third party? ☐ Yes ☐ No

Outpatient treatment

By you from _____ (dd/mm/yyyy) to _____ (dd/mm/yyyy)

Prior to you by Dr _____ in _____ since _____ (dd/mm/yyyy)

Following you by Dr _____ in _____ since _____ (dd/mm/yyyy)

How long have you known the patient? _____(dd/mm/yyyy)

Is the insured person receiving regular treatment from you? ☐ Yes ☐ No

If yes, why? _____

Inpatient treatment

Where? _____

Date of admittance _____ (dd/mm/yyyy) Date of discharge _____ (dd/mm/yyyy)

Anamnesis and progression of the case

_____

_____

_____

Type and duration of treatment _____

Medication (including dosage) _____ ☐ none

Possible earlier illnesses and accidents _____

_____

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Degree and duration of unfitness to work

Degree and duration of unfitness to practice previous profession since occurrence of the first symptoms (independent of the employment market and economic situation **in the case of 100% level of employment**):

_____ % from _____ (dd/mm/yyyy) to _____ (dd/mm/yyyy)

_____ % from _____ (dd/mm/yyyy) to _____ (dd/mm/yyyy)

_____ % from _____ (dd/mm/yyyy) to _____ (dd/mm/yyyy)

_____ % from _____ (dd/mm/yyyy) to _____ (dd/mm/yyyy)

Other acceptable occupation/work

Does any other kind of acceptable work come into question? ☐ Yes ☐ No

Is the insured person working in a new occupation? ☐ Yes ☐ No

If yes, which one? _____ since _____ (dd/mm/yyyy)

Degree of disability in the new occupation _____% from _____ (dd/mm/yyyy) to _____ (dd/mm/yyyy)

DI / LAI / FMI

Has a report been made to the DI agency (early recognition)? ☐ Yes ☐ No

If no, why not? _____

Has a notification been made? ☐ Yes ☐ No

If yes, to whom? ☐ DI ☐ LAI ☐ FMI

Date of report/notification _____ (dd/mm/yyyy)

Resumption of the occupational activity

Can a resumption of the occupational activity or an increase in fitness to work be expected? ☐ Yes ☐ No

If yes, from _____ (dd/mm/yyyy) at _____%

Would occupational measures or case management make sense? ☐ Yes ☐ No

If yes, in what form?
(e.g. retraining, coaching, vocational consultation) _____

_____

_____

Special issues, comments

_____

_____

Place, Date: _____ Stamp, Signature: _____

Definition of "Unfitness to work": Unfitness to work is the full or partial inability to perform acceptable duties in the individual's previous occupation or area of activity caused by impairment of physical, mental or psychiatric health. In the event of a longer duration acceptable employment in another occupation or area of activity will also be taken into consideration (Article 6 ATSG – Allgemeiner Teil des Sozialversicherungsrechts [General Section of the Swiss Federal Social Insurance Act]).

Doctor's fees:

Medical report	CHF 45.-
Medical report with further details	CHF 65.-

Please send the doctor's certificate and bank deposit slip to: **PKRück, Vertrauensärztlicher Dienst, Zollikerstrasse 4, Postfach, 8032 Zürich**