Notification of an occupational disability

Contract number	
Policyholder	
Policy number	

1. Personal details

Name and address	
Date of birth	
Your telephone	
Your email	
Health insurer (name, address)	
Daily sickness allowance insurer (name, address)	
Accident insurer (name, address)	

2. Occupational disability and employment relationship

Cause of the occupational disability					☐ Illness	☐ Accident	
Extent and duration	Degree		%	from		to	
	Degree		%	from		to	
Name and address of the treating physician							

3. Release from the duty of medical confidentiality

The undersigned person authorises the Baloise Life Ltd to process, coordinate and share his/her personal data for the purposes of verifying his/her insurance claim.
In particular, the Baloise Life Ltd may:

- → transmit data to other involved parties (medical treatment providers, social and private insurers, pension funds, public authorities, case managers) for data processing purposes;
- → obtain access to relevant information and records held by medical treatment providers (physicians, chiropractors, psychologists, persons providing services prescribed or ordered by physicians, laboratories, hospitals, rehabilitation clinics, inpatient and outpatient facilities and nursing homes), as well as social (AHV, IV, UVG and KVG insurance, Military Insurance, Unemployment Insurance) or private insurers, pension funds, public authorities, employers, and third-party providers of relevant information.

The undersigned person authorises the persons and institutions concerned and the Baloise Life Ltd to disclose on request any relevant information required for the verification and processing of the insurance claim and releases them from his/her obligation to maintain confidentiality for this purpose.

Place, date	
Signature of the insured person	

4. **Signature** (confirming the accuracy of the information provided)

Place, date	
Stamp and signature of the employer/foundation	