



GROUP HEALTH INSURANCE Notification of incapacity to work

Agency	Please include reference number in all correspondence
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1. Employer	Surname, first name and address with postcode Adobe Systems (Schweiz) GmbH Leutschenbachstrasse 95 8050 Zürich		Policy no. 2807151			
			Phone no.			
			e-mail			
2. Insured person	Surname and first name		Date of birth	AVS number (13-digit)		
	Street		Nationality	Work permit (for foreigners) B C G		
	Postcode, city		Marital status	Private phone no.		
3. Employment	Starting date of employment		Employment contract:			
	Normal occupation		permanent contract			
			temporary contract			
			contract terminated as of:			
	Insured person's working hours:	hours/week	Contractual degree of employment:	%		
	Company's working hrs full time:	hours/week				
4. Start of incapacity to work	Day Month Year		Day Month Year			
	If work resumed, from when?					
5. Doctors' addresses	(doctor or hospital/clinic)					
6. Salary	Insured person subject to tax at source? no yes		CHF per	Hour	Month	Year
	Contractual basic salary incl. cost of living bonus (gross)					
	Child/family allowances					
	Compensation for vacation/public holidays		% or			
	Bonus/13th month's salary (and other)		% or			
	Other salary allow. (e.g. settlement/commission/payment in kind/shift premium)					
	Description:					
7. Postal account or bank account of the company, for transfer of benefits:						
Bank details Adobe Systems: Bank of America, IBAN: CH87 0872 6000 0304 1101 3 / BIC: BOFAGB3SSWI						
8. Other insurance benefits	Is the insured person already entitled to a daily allowance or pension from: health insurance, Suva or another compulsory accident insurance, disability insurance, old age or survivors' insurance, occupational benefit plans, military insurance, unemployment insurance?					
	no		yes		If so, to which one(s)?	
	Does the insured event give rise to benefits from other GENERALI Insurance policies?					
	no		yes		If so, policy no.?	
Has the event been reported to the Federal Disability Insurance for early registration?						
no		yes				
Place and date:			Signature of employer:			
To: insured person >> employer >> GENERALI Assurances			Generali Assurances Soodmattenstrasse 2 Postfach 1047 8134 Adliswil			