LAI minor accident report

Claim no.	Claim no. old

1. Employer

Name and address, postal code

Phone no.

Policy no.

Usual workplace of injured party (business branch)

2. Injured party

Last name and first name

Date of birth

AHV number

Street

Marital status

Nationality

Postal code

Place of residence

Other employer

Bank, branch, account and clearing no. or postal account

Name of the compulsory health insurer (incl. membership number):

3. Employment

Date of employment

Profession practiced

Position:

Working hours of the injured party: hours per week

4. Date of claim

Day | Month | Year | Time (hours, minutes)

5. Location of the accident

Place (name or postal code) and location (e. g. workshop, street)

6. Facts of the case (detailed description of the accident)

Activity at the time the accident occured; course of events, objects involved, vehicles

7. Occupational accident

Objects involved (e.g. machines, tools, vehicles, substances; please give precise descripton)

8. Non-occup. accident

Until when did the injured person last work in the company before the accident (weekday, date, time)?

until:

Reason for absence:

9. Injury

Part of body injured:

Type of damage:

10. Physicians addresses

Physician or hospital/clinic providing initial treatment

Pysician or hospital/clinic providing follow-up treatment

Place and date

Stamp and signature

Reference for the employer

Fill out this minor accident report in the event of the insured is still fit for work or is unfit for a maximum of three calendar days (date of accident plus the following two days).

Exceptions: A white set of forms must be completed instead of this minor accident report in the case of
- occupational illness
- dental damage or
- relapse

We will serve an invoice form upon the attending doctor/doctors.

If you require reimbursement on bills you have already paid, please enclose the receipts and specify the account (bank/postal account) to be credited

Dispatcher:
green form → HDI Global SE, P.O. Box, 8034 Zurich
yellow form → duplicate for their acts
white form → Primary care physician → HDI Global SE, P.O. Box, 8034 Zurich
blue form → Injured → Pharmacist → HDI Global SE, P.O. Box, 8034 Zurich

IDE: CHE-111.964.227 HR

HDI

LAI minor accident report

in duplicate for the employer

Claim no.	Claim no. old

1. Employer

Name and address, postal code

Phone no.

Policy no.

Usual workplace of injured party (business branch)

2. Injured party

Last name and first name

Date of birth

AHV number

Street

Marital status

Nationality

Postal code

Place of residence

Other employer

Bank, branch, account and clearing no. or postal account

Name of the compulsory health insurer (incl. membership number):

3. Employment

Date of employment

Profession practiced

Position:

Working hours of the injured party: hours per week

4. Date of claim

Day | Month | Year | Time (hours, minutes)

5. Location of the accident

Place (name or postal code) and location (e. g. workshop, street)

6. Facts of the case (detailed description of the accident)

Activity at the time the accident occured; course of events, objects involved, vehicles

7. Occupational accident

Objects involved (e.g. machines, tools, vehicles, substances; please give precise descripton)

8. Non-occup. accident

Until when did the injured person last work in the company before the accident (weekday, date, time)?

until:

Reason for absence:

9. Injury

Part of body injured:

Type of damage:

10. Physicians addresses

Physician or hospital/clinic providing initial treatment

Pysician or hospital/clinic providing follow-up treatment

Place and date

Stamp and signature

Medical report LAI

Claim no.	Claim no. old

1. Employer

Name and address, postal code

Phone no.

Policy no.

Usual workplace of injured party (business branch)

2. Injured party

Last name and first name

Date of birth

AHV number

Street

Marital status

Nationality

Postal code

Place of residence

Other employer

Bank, branch, account and clearing no. or postal account

Name of the compulsory health insurer (incl. membership number):

3. Employment

Date of employment

Profession practiced

Position:

Working hours of the injured party: hours per week

4. Date of claim

Day | Month | Year | Time (hours, minutes)

5. Location of the accident

Place (name or postal code) and location (e.g. workshop, street)

6. Facts of the case (detailed description of the accident)

Activity at the time the accident occured; course of events, objects involved, vehicles

7. Occupational accident

Objects involved (e.g. machines, tools, vehicles, substances; please give precise descripton)

8. Non-occup. accident

Until when did the injured person last work in the company before the accident (weekday, date, time)?

until:

Reason for absence:

9. Injury

Part of body injured:

Type of damage:

10. Physicians addresses

Physician or hospital/clinic providing initial treatment

Pysician or hospital/clinic providing follow-up treatment

Physician recordings

Injured body part and type of claim

Medical bill

A. Benefits under collective bargaining			B. Medication and dressing material	
Date	Rate	Tax-points	Type and quantity	Price
			Total B	
			Taxpoint-value	
Please enclose x-ray film	Total		X CHF	Total A
				Total A + B

If the outcome is a disability, you are pleased to require from your employer a medical certificate form. In this case serve a blank medical report with the initial certificate to the insurance.

Date

Stamp and signature of the physician

Post office account no. and bank account no.

8/913.d – 2004

to: Physician providing initial treatment → HDI Global SE, P.O. Box, 8034 Zurich

IDE: CHE-111.964.227 HR

Pharmacy certificate LAI

Claim no.	Claim no. old

Employer	Name and address, postal code	Phone no.	Policy no.
		Usual workplace of injured party (business branch)	
Injured party	Last name and first name	Date of birth	AHV number
	Street	Marital status	Nationality
	Postal code / Place of residence	Other employer	
	Bank, branch, account and clearing no. or postal account		
Date of claim	Day / Month / Year / Time (hours, minutes)		

Notes for the injured person

If the insurance company has agreed to pay the medical costs, your pharmacist will give you the medication prescribed by your physician free of charge.

Obtain all medication from the same pharmacist, to whom you should give this certificate. Please enter the claim number above, which is quoted on all correspondence, or let your pharmacist enter it.

Notes for the pharmacist

The injured person will be informed of an assumption of the cost of treatment by the insurance company. Please ask to see this confirmation, which is your guarantee of payment, and transfer the claim number on it to this pharmacy note.

Injury	Part of body injured:	
	Type of damage:	
Physicians addresses	Physician or hospital/clinic providing initial treatment	Physician or hospital/clinic providing follow-up treatment

Pharmacy bill

Date of surrender	Type and quantity	Price CHF	Price Ct.
	Total		

Please enclose prescription

Date:

Stamp pharmacy:

3 Code

Post office account no. and bank account no.

For settlement via OFAC: 35-1

to: Injured → Pharmacist → HDI Global SE, P.O. Box, 8034 Zurich

IDE: CHE-111.964.227 HR

8/913.d – 2004