

Notification of Disability (Group Life) (in cases of incapacity to work or disability)

1. Information about the insured person

Policy No.

Insured No.

Last name

First name

Street/No.

ZIP code, City/Town

Occupation

Current activity

If you have a short term disability or accident insurance with Zurich, please state your policy and claim number.

2. Incapacity to work/Disability

Reason: Illness Accident

Incapacity to work since: Day Month Year

3. Doctors' addresses

First doctor to give treatment or hospital/clinic

Doctor giving follow-up treatment or hospital/clinic

4. Other insurance institutions (IV, Federal Accident Insurance Institution/LAI, military insurance, health insurers etc.)

Are other insurance institutions involved in this occurrence of loss? Yes No

If so, which ones?

5. Employer's comments

Location

Signature of the employer/of the pension fund

(Your signature is only required if you do not send us this form electronically but by mail.)

Date: Day Month Year

Please send this form directly to: Zurich Switzerland, Group Life Benefits, P.O. Box, 8085 Zurich
or by E-Mail to: Leistungen_KL_Invaliditaet@zurich.ch