

## Notification of incapacity to work

Company \_\_\_\_\_  
 Policy no. \_\_\_\_\_  
 Plan \_\_\_\_\_

This notification must be submitted to us immediately following incapacity to work of at least 3 months

### Details of the insured party (to be completed by the company)

Last name \_\_\_\_\_ First name \_\_\_\_\_  
 Street/no. \_\_\_\_\_ Postcode, town/city \_\_\_\_\_  
 NI no. 756. \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Telephone \_\_\_\_\_ Email \_\_\_\_\_

### Children

Number of children under 20 \_\_\_\_\_ under 25 and in education \_\_\_\_\_  
 1. Last name/first name \_\_\_\_\_ Date of birth \_\_\_\_\_  
 2. Last name/first name \_\_\_\_\_ Date of birth \_\_\_\_\_  
 3. Last name/first name \_\_\_\_\_ Date of birth \_\_\_\_\_

### Incapacity

Absent since \_\_\_\_\_ Please enclose copies of all the documents listed below:

- |   |   |
|---|---|
| <input type="checkbox"/> Illness  | <input type="checkbox"/> Accident                                       |
| – Daily allowance insurer name + policy number: _____                             | – Accident insurer name + policy number: _____                          |
| – Notification of illness   | – Notification of accident  |
| – Health card (from the start, updated)   | – Accident certificate (from the start, updated)                        |
| – Sickness allowance insurer's daily allowance statements (from start to present) | – Accident insurer's daily allowance statements (from start to present) |
| – Authorisation signed by the insured party                                       | – Authorisation signed by the insured party                             |

### Employment relationship

- The employment relationship continues       The employment relationship was ended as of \_\_\_\_\_  
 Please enclose notice of termination

### Treating doctor

Last name \_\_\_\_\_  
 Street/no. \_\_\_\_\_ Postcode, town/city \_\_\_\_\_

Place and date \_\_\_\_\_ Company (stamp and signature) \_\_\_\_\_

**Authorisation** Please have the authorisation signed by the insured party and also enclose the signed authorisation. The reinsurer will then obtain the necessary information itself.

## Authorisation and assignment

Policy no. \_\_\_\_\_

---

### Insured party

Last name	_____	First name	_____
Street/no.	_____	Postcode, town/city	_____
NI no.	756. _____	Date of birth	_____
Telephone	_____	Email	_____
Profession	_____	Position / job performed	_____

---

With regard to the investigation of the claim, verification of the entitlement to benefits by the insured party or further beneficiaries and the execution of recourse against third parties against whom the insured party or the insured party's surviving dependants could have a claim for damages arising from this insured event, the undersigned person expressly authorises Mobilier Lebensversicherungsgesellschaft AG

- To directly obtain all information and documents that appear necessary for investigating the entitlement to benefits and recourse from health insurance funds, health insurance companies, daily sickness benefit insurers, accident insurers, disability insurance offices, pension funds, life insurers, unemployment insurers, liability insurers, military insurers, doctors, psychotherapists, physiotherapists, chiropractors, hospitals, sanatoriums, employers and other persons/institutions. The doctors and the institutions and persons specified are hence unconditionally released from their professional secrecy or medical or legal duty of confidentiality vis-à-vis Mobilier.
- To share data that appears necessary for handling claims and recourse as well as reintegration into working life with third parties, specifically Mobilier, co-insurers or any individual life insurers and the competent disability insurance office, and to obtain the necessary information from these.
- To send documents on the progression of the absence, particularly medical documents, to the responsible disability insurance office in order to simplify the disability insurance process and to increase the chance of reintegration into working life. This process can also be carried out before any registration with the disability insurance office.
- To commission its own expert opinions. Mobilier will pay the costs.

This authorisation is also valid following death.

If the insured party or the insured party's surviving dependants is/are entitled to compensation for damages arising from this insured event from third parties who are liable for the insured event, all claims up to the amount of the regulatory benefits are hereby assigned to the pension fund liable to pay benefits.

With the following signature, the undersigned person grants the aforementioned authorisation in full.

Place and date

Signature of the insured party or the legal representative

\_\_\_\_\_

\_\_\_\_\_