Baloise Incurances, Service Centre

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LAI minor accident report

Claim no.

1. Employer	Name and address with postal code	Phone number	Contract-Nr.
		Normal workplace of the injured person (branch of business)	
2. Injured person	Name	Date of birth	AHV number
	addresse	Martial status	Nationality
	Postal code	Other employer	
3. Employment	Date of employment	Profession carried out	
	Position: ☐ Senior management ☐ middle management ☐ Employee/worker ☐ Apprentice ☐ Trainee		
	Injured person's working hours: (weekly hours) _____		
4. Date of claim	**Day** **Month** **Year** **Time (HH, MM)**		
5. Place of accident	Town (name or postcode) and location (e.g. workshop, road)		
6. facts (Description of accident)	Activity at the time of the accident; how the accident happened, persons involved, objects involved, vehicles Person(s) involved:		
7. Occupatio-nal accident	Objects involved (e.g. machine, tool, vehicle, material; please describe exactly)		
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	Body part: ☒ left ☐ right ☐ unknown Injury:		
10. Address of medical practitioner	First treatment (doctor and/or hospital/clinic)	Subsequently treatment (doctor and/or hospital/clinic)	

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 claim 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

Distribution list:
green form → insurance
yellow form → duplicate for your documentation
white form → injured person → primary care physician → BASLER
blue form → injured person → pharmacy → BASLER

Baloise Insurance Ltd, Claims Switzerland, Aeschengraben 21, P.O. Box, 4002 Basel
Phone 00800 24 800 800, Fax +41 58 285 90 73, schaden@baloise.ch, www.baloise.ch

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LAI minor accident report in duplicate for the employer			Claim no.	
1. **Employer**	Name and address with postal code		Phone number	Contract-Nr.
			Normal workplace of the injured person (branch of business)	
2. **Injured person**	Name		Date of birth	AHV number
	addresse		Martial status	Nationality
	Postal code		Other employer	
3. **Employment**	Date of employment		Profession carried out	
	Position: ☐ Senior management ☐ middle management ☐ Employee/worker ☐ Apprentice ☐ Trainee			
	Injured person's working hours: (weekly hours) _____			
4. **Date of claim**	**Day**	**Month**	**Year**	**Time (HH, MM)**
5. **Place of accident**	Town (name or postcode) and location (e.g. workshop, road)			
6. **facts** (Description of accident)	Activity at the time of the accident; how the accident happened, persons involved, objects involved, vehicles Person(s) involved:			
7. **Occupatio-nal accident**	Objects involved (e.g. machine, tool, vehicle, material; please describe exactly)			
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**	Body part: ☒ left ☐ right ☐ unknown Injury:			
10. **Address of medical practitioner**	First treatment (doctor and/or hospital/clinic)		Subsequently treatment (doctor and/or hospital/clinic)	

Place and date

Stamp and signature

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Medical report UVG

Claim number

1. Employer	Name and address with postcode	Phone. no.	Contract no.
		Injured person's usual workplace (branch of business)	
2. Injured person	Surname and first name	Date of birth	AHV number
	Street	Marital status	Nationality
	Postcode Town/city	Other employer(s)	
3. Employment	Date of employment	Profession carried out	
	Position: ☒ Senior manager ☐ Executive	☐ Employee/worker	☐ Apprentice ☐ Intern
	Injured person's working hours: weekly hours _____		
4. Date of injury	Day Month Year Time (hours: minutes)		
5. Location of accident	Location (name or postcode) and position (e.g. workshop, street)		
6. Facts (description of the accident)	Activity at the time of the accident; circumstances of the accident, people involved, objects involved, vehicles		
7. Occupational accident	Objects involved (e.g. machines, tools, vehicles, work resources; please describe precisely)		
8. Non-occupational accident	When, **prior to the accident,** had the injured person **last** worked at the business (day of the week, date, time)? Up until: Reason for absence:		
9. Injury	Body part affected: ☒ left ☐ right ☐ unclear Type of injury:		
10. Physicians' addresses	Primary care physician, hospital or clinic	Secondary care physician, hospital or clinic	

Physician's information

Body part injured and type of injury

Medical invoice

A. Benefits as per insurance tariff			B. Medications and dressings	
Date	Tariff number	Tax points	Type and quantity	Price
			Total B	
			Tax point value	
Please enclose x-ray films	Total		X CHF	Total A
				Total A + B

If the injury results in an incapacity for work, please ask your employer for a "Medical certificate" form. In this instance, the uncompleted medical certificate must be sent to the insurance company along with the initial certificate.

Date

Stamp and signature of physician

Postal account no. or bank and IBAN

To: Primary care physician → Insurance

Baloise Insurance Ltd, Claims Department Switzerland, Aeschengraben 21, P.O. Box, 4002 Basel, Switzerland

Tel. 00800 24 800 800, Fax +41 58 285 90 73, ukschaden@baloise.ch, www.baloise.ch

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Pharmacy certificate LAI

Claim no.			
1. Employer	Name and address with postal code	Phone Nr.	Contract-Nr.
		Normal workplace of the injured person (branch of business)	
2. Injured person	Name	Date of birth	AHV number
	address with postal code	Phone Nr (if known)	
Date of claim	**Day**	**Month**	**Year**	**Time (HH, MM)**

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.

Pharmacy bill

Date of surrender	Type and quantity	Price CHF	Price Ct.
Please enclose prescriptions	**Total**		

Please send this bill on completion of treatment – at the latest, three months after the date of the accident – to the address listed above.

You can obtain a new pharmacy record by specifying the claim no. from the insurance company if
- there is insufficient space for entering the medication obtained:
- additional medication is required after 3 month.

Date:

Stamp pharmacy:

3	Code	

Post office account no. or bank and IBAN.

For settlement via OFAC: 35-1

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