KPT, PO Box, CH-3001 Bern
kpt.ch

Notification of illness or accident during a stay abroad

Please answer all relevant questions accurately and completely (do not leave a dash in place of answers) and send us the notification of illness or accident at your earliest convenience. This form must be completed by the policyholder or their legal representative.

Policyholder

Last name _____ Policy no. _____

First name _____ Date of birth _____

Telephone/mobile _____ E-mail _____

Stay abroad (only if resident in Switzerland, posted abroad or where the event occurs in a country other than the foreign country of residence)

Duration of the stay abroad from _____ to _____

Reason for the stay abroad

- ☐ Holiday
- ☐ Business trip
- ☐ Purpose of treatment
- ☐ Other reasons
- ☐ Higher education
- ☐ Posted worker
- ☐ Second residence

What is your country of residence? _____

Reason for and duration of treatment

Diagnosis: _____ Accident ☐ Yes ☐ No

Treatment dated _____ to _____

In which country did you fall ill or have an accident? _____

Did you present your KPT insurance card at the time of treatment? ☐ Yes ☐ No

Treatment costs

Country of treatment _____

Exchange rate actually paid _____

Note: only complete questions 1, 2, 8 and 9 in the event of an accident.

1 **Name and address of the employer at the time of the accident** (also applies to part-time jobs and internships)

Working hours _____ days per week _____ hours per week

If unemployed:

When were you last employed and with which employer? _____

Have you since received a daily allowance from unemployment insurance? ☐ Yes, from _____ to _____ ☐ No

KPT, PO Box, CH-3001 Bern
kpt.ch

2 Accident circumstances

Accident date _____ Time _____ Place _____

Precise description of the accident circumstances (geographical location, weather, all people, vehicles, machines and animals involved)

Did the accident occur en route to/from work? ☐ Yes ☐ No

Was a third party to blame for the accident? ☐ Yes ☐ No
(For traffic accidents, see additional questions.)

Name, address and phone number of third party

Name and address of the liability insurer (precise name with policy no.)

Name, address and phone number of witnesses

Was a police report created? ☐ Yes ☐ No

From which official body? _____

3 Doctors' bills

No.	Treating physician		Number of visits, consultations, etc.	Amount in foreign currency	Amount in CHF
	Dr				
	Dr				
	Dr				

4 Bills for additional services

No.	Number	Details	*Details about the parts of the body X-rayed, etc.	Amount in foreign currency	Amount in CHF
		X-ray(s)*			
		Laboratory test(s)			

5 Pharmacy bills (enclose doctor's prescription)

No.	Enter the medication names one at a time	Amount in foreign currency	Amount in CHF

KPT, PO Box, CH-3001 Bern
kpt.ch

6 Miscellaneous costs (physiotherapy, medical aids, transport, etc.)

No.	Provider's name and address	Amount in foreign currency	Amount in CHF

7 Hospital bills

Admission date		Discharge date		Amount in foreign currency	Amount in CHF
Room & board		Number of days at			
Other hospital costs (operating theatre, analyses, doctor, etc.):					
Nature of operation(s) or reason for treatment					

8 Other insurance

Which of the following compulsory and/or supplementary accident insurance policies do you have and what is the extent of your cover? Do you, for example, have full coverage for medical expenses or only as an add-on to your health insurance? Do you have income protection insurance? If so, what is the extent of your cover?

Please provide full details. If you do not have any other accident insurance policies, please select No in each case.

Insurance		Insurer		
Compulsory accident insurance from the employer (in accordance with the AIA)	☐ Yes ☐ No	Last name Agency Policy no.		
Supplementary/additional insurance further to compulsory accident insurance from an employer (in accordance with the AIA)	☐ Yes ☐ No	Last name Agency Policy no.		
Private accident insurance	☐ Yes ☐ No	Last name Agency Policy no.		
Other insurance (e.g. from a sports club)	☐ Yes ☐ No	Last name Agency Policy no.		
Do you receive a pension from federal invalidity insurance, SUVA, AI, MI or private insurance?	☐ Yes ☐ No	From which? Monthly pension CHF Disability	Since when? %	

KPT, PO Box, CH-3001 Bern
kpt.ch

Additional questions in connection with a traffic accident

9

	Vehicle used by you		Collision vehicle	
	Type (e.g. bicycle, moped, car)		**Type** (e.g. bicycle, moped, car)	
	Police case file no.		**Police case file no.**	
Owner	Last name		Last name	
	Address		Address	
	Telephone no.		Telephone no.	
Liability insurance	Last name		Last name	
	Address		Address	
	Telephone no.		Telephone no.	

Comments

The undersigned confirms that all questions have been answered truthfully and in full, and authorises KPT to access all files relating to the accident (e.g. medical documents, files from Suva, MI and the private accident insurer plus official files).

Obligation to provide information (Art. 27 GSSLA)

Please check if other social insurance types have an obligation to provide benefits, for example OASI/IV, military insurance or compulsory accident insurance under the AIA, as well as any other benefits and victim support.

KPT will only pay its benefits in accordance with the insurance conditions if all original bills for the costs listed above are attached to this 'Notification of illness or accident' form. To facilitate smooth processing of the claim, please provide us with documentary evidence in as much detail as possible, adding explanatory notes where necessary.

KPT reserves the right to demand original bills.

Place and date ✘ _____ Signature ✘ _____

Policyholder or legal representative