

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
	adresse	Marital status	Nationality
	Postal code	Other employer	
3. Employment	Date of employment	Profession carried out	
	Position: <input type="checkbox"/> Senior management <input type="checkbox"/> middle management <input type="checkbox"/> Employee/worker <input type="checkbox"/> Apprentice <input type="checkbox"/> 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. Occupational 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:	<input type="checkbox"/> left	<input type="checkbox"/> right <input type="checkbox"/> 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

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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

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
	adresse			Marital status	Nationality
	Postal code			Other employer	
3. Employment	Date of employment			Profession carried out	
	Position: <input type="checkbox"/> Senior management <input type="checkbox"/> middle management <input type="checkbox"/> Employee/worker <input type="checkbox"/> Apprentice <input type="checkbox"/> 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)				
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	Person(s) involved:				
7. Occupational 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:			<input type="checkbox"/> left	<input type="checkbox"/> right <input type="checkbox"/> 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

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	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