COPRÉ

NOTIFICATION OF INABILITY TO WORK

Affiliated company: ..... Contract No.: .....

Personal data of the insured person

Name and first name: ..... Date of birth: .....

AVS No.: ..... Gender: ☐ M ☐ F

Address: .....

.....

Tel. private/mobile: ..... Mail: .....

Civil status from: ..... ☐ single ☐ married ☐ divorced

☐ bound by a registered partnership ☐ partnership dissolved ☐ widow(er)

Information concerning inability to work and professional situation:

Cause of the inability to work: ☐ illness ☐ accident

Degree and duration ..... % from ..... to .....

..... % from ..... to .....

..... % from ..... to .....

Name and address of general physician

.....

Enclose a copy of medical certificates

Professional situation:

- professional activity exercised before the start of the inability to work: .....
- will the person insured be able to resume the same professional activity: ☐ yes ☐ no
- is the employment agreement terminated, or will it be? ☐ yes ☐ no
- If yes, indicate the date of termination of the employment agreement: .....

Information concerning the insurances:

☐ insurer for loss of earnings, illness (name and address): .....

.....

.....

☐ insurer for accidents (LAA) (name and address): .....

.....

.....

Enclose a copy of the notification sent to the insurer for loss of earnings, together with the daily allowance statements.

Place and date: ..... Stamp/Signature of employer: .....

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