

To the
Social Insurance Institution
for Commerce and Industry (SVA)

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Receipt stamp

SICKNESS NOTIFICATION
at supplementary insurance for sickness benefit (§ 106 GSVG) as well as
Support during long-term illness (§ 104a GSVG)

Person insured	Social Security Number – date of birth
Address	

Unfit for work since **probable duration of the incapacity**

Fit for work from

Diagnosis

Hospital care from to in the

Bed rest yes no **Starting** from to o'clock

The beginning of the incapacity for work is to be indicated by the day on which the incapacity occurred.

Please tick the relevant boxes if the incapacity for work was caused by one of more of the following.

- | | |
|--|--|
| <input type="checkbox"/> Accident at work | <input type="checkbox"/> Sports or domestic accident |
| <input type="checkbox"/> Traffic accident | <input type="checkbox"/> Resulting from a previous accident |
| <input type="checkbox"/> Brawl | <input type="checkbox"/> Resulting from an earlier non-remedied illness |
| <input type="checkbox"/> Accident insured occupational illness | <input type="checkbox"/> Intentionally brought about incapacity for work |

.....
Date

.....
Doctor's stamp and signature

Information about processing your personal data according to the paragraph 13 of general regulations can be found at our website www.svagw.at/vvt.

Social Security Number – date of birth:

To be completed by the insured person.

For payment of support benefit we require the following information:

- I am personally required to work in order to maintain my business
 yes no
- My average daily working period is hours
- The number of employees (including part-time staff) in my company is and the yearly average is expected to
 exceed 24 not exceed 24.

This number includes apprentices and/or disabled persons as defined by the Disabled Persons Act, BGBl. No. 22/1970.

Account:

I request the transfer to my account at the

IBAN:

BIC:

Furthermore, I declare that I have given the information truthfully and have noted that in the event of false statements wrongfully accepted benefits must be repaid.

.....
Signature

Please note the following notification deadlines. When exceeding these deadlines the sickness benefit/support benefit cannot be paid until the time of the notification.

<p>Sickness benefit with supplementary insurance</p> <p>Initial notification within 7 days from the start of the incapacity for work.</p> <p>Further notifications must be confirmed by a doctor every 14 days and submitted within 7 days.</p> <p>If the incapacity for work lasts longer than 42 days, an additional sickness notification is required and at the same a further request for payment of support benefits must be submitted.</p> <p>The ability to work is to be reported immediately.</p>	<p>Support benefit</p> <p>Medical determination of incapacity for work within 4 weeks from the start of the incapacity due to illness as well as notifying the SVA within 2 weeks after the medical determination.</p> <p>Further notifications must be confirmed by a doctor every 14 days and submitted within 7 days.</p> <p>The ability to work is to be reported immediately.</p>
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