groupemutuel

General terms and conditions for SafetyPro individual accident insurance

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The risk-bearing insurer is Groupe Mutuel Assurances GMA SA, hereinafter referred to as the insurer.

A. General principles

Art. 1 Legal bases of the contract

The legal bases of the contract are:

1. These general terms and conditions of insurance (CGA), the provisions of the insurance policy and any addendums thereto.
2. The statements made in the insurance proposal and any other statements of the insured person.
3. The Federal Law on Insurance Contracts (LCA/VVG).
4. The Federal Law on Data Protection (LPD/DSG).
5. The Federal Law on Accident Insurance (LAA/UVG) applies mutatis mutandis were provided for by these general terms and conditions.
6. The Swiss Code of Obligations (CO).

Art. 2 Purpose of the insurance

1. The insurance covers occupational accidents, non-occupational accidents and occupational illnesses, as defined by the law on compulsory accident insurance (LAA/UVG) and the guarantees set out in the policy.
2. Benefits are payable only if the accident, bodily injury or last exposure to danger before the occupational illness was declared occurred during the validity of the contract.
3. For certain occupational diseases specifically provided for in the LAA/UVG, benefits are calculated in accordance with that law. However, only the percentage of the duration of exposure to the hazard during the period of coverage of this policy in relation to the total duration of exposure is taken into account.

Art. 3 Insured persons

1. Any person who is resident in Switzerland, is 15 years old and has not reached retirement age (AVS/AHV) may join SafetyPro.
2. Free transfer
   a. A person who leaves a group supplemental accident insurance policy taken out with the insurer may transfer to this individual insurance, subject to the terms and conditions of the group insurance.
   b. As part of a transfer, cross-border commuters who are gainfully employed in Switzerland may also request to join the insurance.

Art. 4 Territorial validity
The insurance is valid worldwide.

B. Scope of insurance

Art. 5 Start and end of contract

1. **Start of contract**
   The policy indicates the effective date of the contract as well as its the expiry date, which is 31 December of a calendar year.
2. **Automatic renewal of the contract**
   Upon expiry of the contract and unless it is terminated by registered letter no later than 30 September of the calendar year, the contract will be automatically extended from year to year.
3. **End of contract for all coverages**
   a. in case of termination by the insured person or the insurer;
   b. if premiums are not paid in accordance with Art. 18 of these general terms and conditions;
   c. when the insured transfers his place of residence abroad, except for cross-border workers who are gainfully employed in Switzerland and entitled to free transfer in accordance with Art. 3, para. 2 let. b of these general terms and conditions.
4. **End of contract for daily allowance coverage**
   a. at the end of the contract according to para. 3;
   b. upon termination of the gainful employment;
   c. at the end of the month during which the insured person reaches AVS/AHV retirement age;
   d. when the insured person residing abroad can no longer prove that he receives income from a gainful activity in Switzerland.

Art. 6 Start and end of insurance coverage

1. Insurance coverage begins when the policy takes effect.
2. Insurance coverage ceases in one of the following cases:
   a. at the end of the contract in accordance with Art. 5, paras. 3 and 4 of these general terms and conditions;
   b. if the contract is suspended.

Art. 7 Termination following a loss

1. After each claim which the insurer is liable for in terms of benefits, the insured person may withdraw from the contract at the latest 14 days after having become aware of the payment of the allowance. If the insured person withdraws from the contract, coverage ceases 14 days after the insurer receives the notice of termination. The insurer shall remain entitled to the premium for the current insurance term if the policyholder terminates the contract within one year of the insurance coverage coming into force. In all other cases, the premium is due only until the end of the contract.
2. The insurer expressly waives its right under the LCA/VVG to withdraw from the contract in the event of a loss, save in case of abuse, misrepresentation, fraud, non-disclosure or attempts to do so.

C. Benefits

Art. 8 Treatment costs (healthcare benefits and reimbursement of costs)

A. Entitlement to benefits

If treatment costs are insured, and according to the chosen variant, the insurer will pay the benefits listed below not payable by LAA/UVG insurance and LAMal/KVG basic health insurance.
The insurer covers the costs of treatments that are effective, appropriate and economical.
Coverage begins on the day of the accident and lasts for a maximum of five years from that date.
This coverage falls within the scope of indemnity insurance.

1. **Medical treatment**
   Care and the costs of treatment carried out by recognised medical practitioners. The insurer shall make available a list of recognised medical practitioners.
2. **Medication**
   The cost of necessary medicines prescribed or dispensed by a doctor, with the exception of pharmaceutical products for special application (LPPA/LPPV).
3. **Hospitalisation**
   a. **Coverage**
      In accordance with the rates recognised by the insurer for the relevant coverage stipulated in the policy:
      – hotel services relating to accommodation and catering;
      – recognised diagnosis and therapeutic measures;
      – patient care in hospital;
      – doctors' fees;
      – fees of doctors who provide care in hospital on a self-employed basis (licensed doctors).
   b. **Approved facilities**
      Only benefits provided by hospitals approved by the insurer are covered. Approved facilities have concluded a tariff agreement with the insurer for the corresponding wards.
      The insurer shall make available a list of recognised facilities.
      Before each treatment, the insured must find out whether the facilities where he will be treated are recognised by the insurer.
      If an insured person is hospitalised in a non-recognised facility, he will be entitled to CHF 800 per day in the semi-private ward and CHF 1,000 per day in the private ward.
      The insurer reserves the right to refuse or restrict the fees of licensed doctors who do not have a tariff agreement with the insurer.
   c. **Deduction for room and board costs**
      The deduction made by the LAA/UVG insurer for room and board costs during a stay in a hospital is also covered.

4. **Convalescence and other cures**
   Prescribed treatment in a cure centre or convalescence facility recognised by the insurer. Additional costs for room and board are covered up to CHF 200 per day, for a maximum of 30 days per stay, up to maximum 120 days for the same accident. The insurer shall make available a list of recognised facilities.
5. **Alternative medicine**
   The cost of the following therapies provided they are administered by a qualified doctor or a natural therapy practitioner recognised by the insurer, up to CHF 100 per session, for a maximum of CHF 2,500 per case. The insurer shall make available a list of recognised practitioners.
   List of therapies:
   Naturopathy
   Acupuncture, aromatherapy, auriculotherapy, bioresonance, biotherapy, chromotherapy, electroacupuncture, geobiology, herbal medicine, homeopathy, iridology, colon hydrotherapy, laser therapy, magnetic field therapy, magnetotherapy, moratherapy, naturopathy, nutritional counselling, oxygenotherapy, phytotherapy, sympathicotherapy, cupping.
   Manipulation techniques
   Acupressure, lymphasizing, etiopathy, postural integration, kinesiology, massage therapies, anthroposophic medicine, mesotherapy, metamorphosis, myofascial release therapy, orthobionomy, osteopathy, polarity, energy balancing, reflexology, reiki, rolfing, rolfing, shiatsu, autogenic training, trager.
   Other
   Bio-energetics, eurythmy, rebirthing, sophrology, Tomatis Method
6. **Medical aids and appliances**
   The costs of the first acquisition or rental of medically prescribed appliances which are designed to compensate a physical injury or the impairment or loss of a function (prosthesis, spectacles, hearing devices and orthopaedic auxiliary appliances), according to the list made available by the insurer.
   The repair or replacement cost (new value) of aids and devices designed to physically or functionally replace a body part provided such aids or devices were damaged or destroyed during an insured accident which caused the insured a physical injury necessitating treatment.
7. **Home help and home care**
   The insured person is entitled to home help and home care prescribed by a doctor.
   Home help is provided if an insured has a medically certified incapacity of at least 50% and as long as it is provided by a person who carries out this activity in a professional capacity on his or her own behalf or on behalf of an official company or organisation.
   The limitation for home help and home care is CHF 100 per day, at a maximum of CHF 6,000 per case.
8. **Childcare**
   The insured is entitled to reimbursement of the costs of childcare for children up to the age of 12, provided that the care is provided by the Red Cross or an official institution with the same purpose.
   Childcare is covered within the limitations below, insofar as it entails additional costs for the insured and as long as the insured can prove that he is at least 50% incapacitated, as certified by a doctor.
   The limitation for childcare is CHF 150 per day, at a maximum of CHF 6,000 per case.
9. **Transport costs**
   The medically necessary costs of transporting the insured to the place of treatment are reimbursed. If justified on medical or technical grounds, air transport costs are reimbursed.
10. **Removing and transporting the body**
   The cost of removing and transporting the body to the place of burial is reimbursed if the insured died as a result of an insured accident.
11. **Search operations**
   The insurer shall pay in addition to the LAA/UVG insurance or to the LAMal/KVG health insurance the necessary costs for search and rescue operations, up to a maximum of CHF 100,000 per case.

B. Healthcare providers
The insurer may make available lists of recognised or excluded healthcare providers.
These lists can be updated at any time and are available on the insurer's website or on request.
The lists valid at the time of treatment are decisive.
A modification on the list does not entitle the policyholder to a right of termination.

C. Third-party benefits
If treatment costs under this article are payable by any other Swiss or foreign social insurance, the insurer shall pay supplemental benefits up to the total cost of treatment.

D. Excess benefits
When the costs of recovery are covered by several insurers, the total benefits may not exceed the actual total costs resulting from the accident. The insurer is only liable proportionately to the ratio that the benefits insured by it bears to the total benefits insured by all insurers.

Art. 9 Hospital daily allowance

1. **Entitlement to benefits**
   The insurer will pay the hospital daily allowance stated in the policy for the length of the insured's hospitalisation or cure provided that the hospitalisation or cure is medically necessary and was prescribed by a doctor.
   The hospital stay is medically necessary if the related medical treatment assists in improving the state of health or in preventing an unfavourable development of the latter.
   In addition, the stay in a medically controlled convalescence center will only be covered if the insured was following a medical treatment before the beginning of the cure.
   When care is provided at home upon medical prescription in order to avoid a hospital stay, the insurer will pay the corresponding daily allowance to the insured, equal to half the agreed hospital daily allowance.
2. **Duration of benefits**

The hospital daily allowance is paid from the day of the accident:

- for hospital stays, during a maximum of 360 days per case;
- for cure or convalescence stays, during a maximum of 30 days per stay, up to 120 days for the same case;
- if care is provided at home, half of the agreed hospital daily allowance is paid by the insurer during a maximum of 200 days of home care per case.

3. Type

This benefit falls within the scope of fixed-sum insurance.

Art. 10 Daily allowance

1. Entitlement to benefits

The insurer shall pay the insured person who has been medically certified as being unable to work the daily allowance benefit agreed in the policy. The insured daily allowance is payable on expiry of the waiting period agreed in the policy.

Upon receipt of an interim or final medical certificate, the insurer will indemnify the insured until the date stated on the practitioner's certificate but not beyond the end of the current month unless the insurer requests an additional medical examination.

2. Duration of benefits

The daily allowance is paid for 730 days per accident within a period of five years from the date of the accident, but in any case, no later than the payment of a disability benefit in accordance with Art. 11 of these general terms and conditions.

3. Partial incapacity for work

In the event of a partial incapacity for work, the insurer will pay a daily allowance reduced pro rata the degree of incapacity for work for the period specified in the previous paragraph.

The days of partial incapacity are counted as full days, both for the calculation of the waiting period and for the duration of the benefits.

4. Third-party benefits

If the daily allowances due are paid in conjunction with benefits from Swiss or foreign social insurance bodies, these daily allowance benefits will be reduced by the amount paid by these social insurance bodies, within the limits of the benefits provided for in the policy.

5. Type

This benefit falls within the scope of fixed-sum insurance.

Art. 11 Disability

If provided for by the policy, the insurer pays, depending on the selected coverage:

- a lump-sum disability benefit (in accordance with para. 1(c) below); and/or,
- the cost of plastic surgery (in accordance with para. 2 below); and/or
- the cost of professional retraining (in accordance with para. 3 below).

1. Lump-sum benefits

a. Entitlement to benefits

A lump-sum disability benefit will be paid as soon as the disability is recognised as being permanent and subject to Art. 13 of these general terms and conditions.

b. Degree of disability

The degree of disability is set in accordance with the scale of impairment in Annex 3 of the Ordinance on Accident Insurance (OLAA/UVV) and in accordance with SUVA's tables.

In case of a partial functional disability, the percentage is reduced proportionally. If the degree of disability cannot be established in accordance with the above rules, it will be set by analogy taking into account the seriousness of the impairment based on the medical report. If several organs or parts of the body are affected by the same accident, the relevant percentages will be weighted. Notwithstanding, the degree of disability cannot exceed 100%.

c. Calculation of the lump-sum amount

The lump-sum amount in case of disability is calculated based on the degree of disability, the agreed insured amount and the chosen progression.

If the insured was already disabled before the accident, the lump-sum amount payable by the insurer is proportionate to the disability directly caused by the accident.

d. Progression

In the case the progressive disability lump-sum amount was chosen, the disability lump-sum amount is calculated based on the chosen progression in accordance with the following table:

Benefits in % of the insured amount

Disability rate (%)	Compensation no progression	according to variants A	B
100	**100**	**225**	**350**
99	99	222	345
98	98	219	340
97	97	216	335
96	96	213	330
95	**95**	**210**	**325**
94	94	207	320
93	93	204	315
92	92	201	310
91	91	198	305
90	**90**	**195**	**300**
89	89	192	295
88	88	189	290
87	87	186	285
86	86	183	280
85	**85**	**180**	**275**
84	84	177	270
83	83	174	265
82	82	171	260
81	81	168	255
80	**80**	**165**	**250**
79	79	162	245
78	78	159	240
77	77	156	235
76	76	153	230
75	**75**	**150**	**225**
74	74	147	220
73	73	144	215
72	72	141	210
71	71	138	205
70	**70**	**135**	**200**
69	69	132	195
68	68	129	190
67	67	126	185
66	66	123	180
65	**65**	**120**	**175**
64	64	117	170
63	63	114	165
62	62	111	160
61	61	108	155
60	**60**	**105**	**150**
59	59	102	145
58	58	99	140
57	57	96	135
56	56	93	130
55	**55**	**90**	**125**
54	54	87	120
53	53	84	115
52	52	81	110
51	51	78	105
50	**50**	**75**	**100**
49	49	73	97
48	48	71	94
47	47	69	91
46	46	67	88
45	**45**	**65**	**85**
44	44	63	82

Benefits in % of the insured amount

Disability rate (%)	Compensation no progression	according to variants A	B
43	43	61	79
42	42	59	76
41	41	57	73
40	**40**	**55**	**70**
39	39	53	67
38	38	51	64
37	37	49	61
36	36	47	58
35	**35**	**45**	**55**
34	34	43	52
33	33	41	49
32	32	39	46
31	31	37	43
30	**30**	**35**	**40**
29	29	33	37
28	28	31	34
27	27	29	31
26	26	27	28
25	**25**	**25**	**25**
24	24	24	24
23	23	23	23
22	22	22	22
21	21	21	21
20	**20**	**20**	**20**
19	19	19	19
18	18	18	18
17	17	17	17
16	16	16	16
15	**15**	**15**	**15**
14	14	14	14
13	13	13	13
12	12	12	12
11	11	11	11
10	**10**	**10**	**10**
9	9	9	9
8	8	8	8
7	7	7	7
6	6	6	6
5	**5**	**5**	**5**

e. Type

This benefit falls within the scope of fixed-sum insurance.

2. Aesthetic damages

If in the accident the insured suffered serious permanent disfigurement (aesthetic damage) which does not qualify for a lump-sum disability benefit under item (a) above but nevertheless constitutes a psychological prejudice which is certain to jeopardise his economic future or social status, the insurer shall pay an indemnity equal to:

- 10% of the insured amount stipulated in the policy if the damage affects the face;
- 5% of the insured amount stipulated in the policy if the damage affects other parts of the body.

The indemnity for such damages shall not exceed CHF 20,000 per case. This benefit falls within the scope of fixed-sum insurance.

3. **Cost of professional retraining**
   If, as a result of the same accident, the insured has to be retrained for another profession, the insurer shall be liable, in addition to the benefits under paras. 1 and 2, for reasonable costs not covered by other insurers; such costs may not exceed CHF 20,000 per case. This benefit falls within the scope of indemnity insurance.

Art. 12 Lump-sum in case of death

1. **Entitlement to benefits**
   If the accident causes the death of the insured, the insurer shall pay the agreed lump-sum death benefit, subject to Art. 13 of these general terms and conditions, to the beneficiaries in the following order:
   a. surviving spouse or registered partner. If the marriage or registered partnership was contracted after the accident, the existence of the right is subject to the condition that the promise of marriage or partnership was published before the accident or that the marriage or partnership had lasted at least two years at the time of the insured's death;
   b. failing this, the deceased's children under 18 or, if they are still studying or in apprenticeship, under 25, are entitled to a lump-sum death benefit in equal shares. Children who were dependent on the deceased for their education and maintenance at the time of his death are equated with his own children provided he supported them durably and at no charge;
   c. failing this, an unmarried or unregistered physical person who is a non-relative (also applies to same-sex partners) and who cohabited uninterruptedly with the deceased in a common-law marriage or registered partnership for the last five years before the death.
   d. Other survivors
      In the absence of survivors mentioned in letters a, b and c, the lump-sum capital is payable to:
      – the children of the insured person who do not meet the criteria of letter b;
      – failing this, the natural persons whom the insured person has designated as beneficiaries of this lump-sum by will or notarial act;
      – failing this, the father and mother of the insured person;
      – failing this, the brothers and sisters of the insured person.
   e. Absence of survivors
      – If the insured person has none of the above survivors, the insurer shall only pay the share of burial costs not covered by another insurer up to the lump-sum death benefit but not more than CHF 20,000.
2. **Accrual of benefits**
   Any disability benefits already paid for the consequences of the same accident (see Art. 11 of these general terms and conditions) shall be deducted from the death benefits.
3. **Fault on the part of a survivor**
   Cash benefits payable to the relatives or survivors of the insured shall be reduced if the latter caused the realisation of the risk deliberately or by deliberately committing a crime or an offence.
4. **Type**
   This benefit falls within the scope of fixed-sum insurance, except for possible burial costs, which are covered by indemnity insurance.

Art. 13 Benefits at retirement age (AVS/AHV)

1. When the insured reaches AVS/AHV retirement age, the insured amounts are limited to the maximum amounts, as follows:
   – hospital daily allowance of CHF 20 per day;
   – in the event of death to CHF 30,000;
   – in the event of disability to CHF 100,000 (variant without progression).
   These limits apply to accidents occurring after the end of the year in which the insured has reached AVS/AHV retirement age.
2. Daily allowance insurance coverage and the resulting entitlement to benefits for any current case will end at the end of the month in which the insured person reaches AVS/AHV retirement age.

Art. 14 Exclusions from the insurance

1. No insurance benefits will be paid for occupational and non-occupational accidents for which the LAA/UVG does not or would not apply (cases of refusal of benefits).
2. In addition, are excluded from the insurance:
   – cases of non-disclosure;
   – cases of fraud or insurance fraud attempts;
   – intentional damage;
   – accidents caused by the insured while committing a crime or an offence;
   – accidents caused by earthquakes;
   – the consequences of events of war:
     – in Switzerland;
     – abroad, unless the events catch the insured by surprise in the country where he is staying and provided the accident occurs no more than 14 days after the start of such events;
   – accidents during military service abroad;
   – participation in acts of war, terrorism or organised crime;
   – damages caused by ionising rays of any kind. This exclusion does not apply to conditions caused by radiation treatments prescribed by a doctor following an insured event.

Art. 15 Reduction of benefits in the event of gross negligence, extraordinary dangers and hazardous activities

1. The insurer waives its rights to reduce its benefits for all accidents insured under this contract and caused through gross negligence, extraordinary danger or hazardous activities, within the meaning of the LAA/UVG legislation.
2. Art. 14 of these general terms and conditions remains reserved.

Art. 16 Recourse against liable third parties

Upon occurrence of an insured event, in the case of benefits falling within the scope of indemnity insurance, the insurer is subrogated, within the limits of the benefits provided by it, to the rights of the insured person against any third party liable for the event.

D. Premiums

Art. 17 Calculation of the premiums

1. Premiums are calculated based on the insured amounts and according to the insured person's age group and sector of activity.
2. An insured person who reaches the last year of his age group is automatically transferred into the next age group at the beginning of the following calendar year.
3. The applicable age groups are:
   – 15 to 25 years;
   – from age 26, age groups are graduated in five-year brackets.
4. The adjustment of the premium when moving to a higher age group is deemed to be approved if the insurer has not received any notice of termination before the end of the calendar year.
5. Premium rates may be adjusted when new circumstances come into effect (e.g. change in the insured's activity). In the event of an increase in premium rates, the policyholder may exercise a right of termination within 30 days from the date of notification (date of receipt by the insurer). If the policyholder does not terminate the contract, the adjustments in premium rates shall be deemed accepted.

Art. 18 Payment of premiums

1. The insured person is the debtor of the premiums.
2. Premiums are payable within the time limit specified in the policy.
3. If the premiums are not paid when due, the insurer shall send a formal notice to the debtor, including costs, requesting payment within 14 days of the notice and pointing out the consequences of late payment. If premium arrears and costs are not paid within the additional time limit, the insurer's obligations shall be suspended thereafter.
4. If the insurer does not institute debt collection proceedings for the premium arrears and costs within two months of the expiry of the 14-day time-limit, the contract is deemed to have ended.
5. During periods of suspension:
   – Claims that have occurred are not covered.
   – The obligation to pay benefits for claims in progress is suspended from the date of expiry of the period of notice. Payment resumes on the date on which the outstanding premiums and costs have been paid. In this case, the days of incapacity for work for the ongoing claims will be deducted from the duration of entitlement to benefits.
6. The premium billing period is at least one month, except for the month in which admission to the insurance begins or ends.

Art. 19 Changes in premiums

1. The premiums for one or more insured benefits (Art. 8 to 12 of these general terms and conditions) may be adjusted each year.
2. Adjustments are made as at 1 January of each calendar year.
3. The insurer shall inform the insured person of the new provisions no later than 25 days before the expiry of the current year. If the insured person objects to the change in the contract, he may request termination of all or part of the contract at the end of the current year.
4. Changes are considered approved if the insurer has not received any notice of termination before the end of the calendar year.

E. Obligations and other provisions

Art. 20 Obligation of the insured person

1. The insured must notify the insurer promptly of any accident requiring medical attention or causing an incapacity for work. If the insured dies as a result of the accident, this obligation is incumbent upon the survivors of the deceased who are entitled to benefits.
2. The policyholder undertakes to provide, automatically or at the insurer's request, any document capable of establishing the entitlement to benefits (medical certificates, medical reports, etc.).
3. The insured person must notify the insurer of any changes in circumstances that may affect the entitlement to benefits (change in the degree of incapacity, registration to the unemployment insurance fund, entitlement to third-party benefits, etc.).
4. The insured person must provide the insurer with all relevant documents, including a power of attorney authorising the insurer to obtain information from third parties, so that the insurer can determine whether the claim is well-founded, otherwise the right to benefits may be forfeited.
5. The insured shall release his attending practitioners from medical and professional secrecy vis à vis the insurer's medical advisor.
6. The insured person must cooperate with the insurer and with the third parties appointed by the insurer (claims inspector, officers, doctors, etc.). The insured person shall follow the insurer's instructions, provide the requested documents and answer any questions. If the insured fails to appear for a medical examination on the appointed date without good reason, the insurer reserves the right to reduce or refuse benefits, or to demand that any benefits already paid out be refunded and to charge the insured person for the missed medical appointment.
7. The insured person must consult a licensed doctor from the start of the incapacity and follow his prescriptions.

The insured person must avoid any conduct that could impede recovery or prolong incapacity.

8. Before each treatment, the insured must find out whether the facilities where he will be treated are recognised by the insurer.
9. The insured person must submit an application for benefits to the AI/IV disability insurance office no later than six months from the beginning of the incapacity or, upon request of the insurer, to another social insurance institution.
10. The insured person is required to limit damages, including cooperate with social insurance institutions (disability insurance, accident insurance, military insurance, etc.).
11. Within reasonable limits, the insured person shall participate in a treatment or in professional retraining measures designed to significantly improve his capacity for work or offer new earning prospects.
12. The insured person must inform the insurer of any increase in risk (e.g. change of insured occupational activity).
13. In case of fraud or insurance fraud attempts, the insured person will be required to pay for the investigation expenses incurred by the insurer for verifying the incapacity as well as for following up the case.
14. Failure to comply with these obligations may lead to sanctions on the part of the insurer, which may extend to the refusal of benefits.
15. The sanctions shall not apply if the breach of duty is not due to a fault or if the insured person can prove that the breach of duty had no influence on the occurrence of the event and on the scope of benefits.

Art. 21 Change in insured risks

1. The policyholder shall promptly notify the insurer if a significant event (e.g. change in the insured activity or occupation) is liable to aggravate risks.
   If he fails to do so, the insurer shall be no longer be bound by the contract.
2. Aggravated risks which are duly notified by the policyholder shall be covered by the insurer. The insurer may, however, terminate the contract within 14 days of receiving the policyholder's notification. Should this be the case, coverage ceases 14 days after the insurer receives the notice of termination.
3. Additional premiums, if any, are due from the outset of the aggravated risk.

Art. 22 Assignment and pledging of benefits

The insured person may not assign or pledge claims against the insurer without the latter's consent.

Art. 23 Compensation

1. The insurer may offset due benefits against receivables from the insured person.
2. The insured person has no right to offset benefits against the insurer.

Art. 24 Adjustment of insurance conditions

1. The insurer has the right to adjust these general terms and conditions of insurance.
2. The new terms and conditions apply to policyholders and to the insurer if they are adjusted during the term of validity of the insurance.
3. The insurer shall notify the policyholders of these adjustments. If the policyholder does not accept the changes, he may terminate the contract effective the date on which the adjustments take effect. If termination is not notified to the insurer within 30 days, the new provisions are deemed to have been accepted.
4. Exceptions to the right of termination are adjustments to the terms and conditions of insurance that do not result in any disadvantage for the insured person.

Art. 25 Notices

1. All notices from the policyholder must be sent in writing to the postal or email addresses indicated on the insurer's official documents, or by any other means that can be proven by a text made available by the insurer, with the exception of social networks.
2. Notices by the insurer are valid if they are sent to the last postal or email address communicated to the insurer by the policyholder. These notices may be sent in writing or by any other means that can be proven by a text made available by the insurer.
3. The insurer may also send general communications to policyholders via the magazine for its insured persons. The insured person who no longer wishes to receive the magazine may so request in writing from the insurer, or by any other means made available by the insurer, in which case the insurer shall not be liable for the communications published. These communications may also be made on the insurer's website and in a document enclosed when sending out the insurance policies each year.

Art. 26 Place of performance and place of jurisdiction

1. The obligations arising from the contract shall be performed in Switzerland and in Swiss francs.
2. In case of a dispute, the policyholder, the insured person or beneficiary may choose the jurisdiction of the courts of his place of residence in Switzerland, or of the insurer's headquarters or, if the insured is domiciled abroad, that of his place of work in Switzerland.

Art. 27 Data protection

Personal and sensitive data

Groupe Mutuel Services SA processes the personal and sensitive data of the policyholder, the insured person and, where applicable, their beneficiaries or related persons (hereinafter referred to as the "persons concerned") on behalf of Groupe Mutuel Assurances GMA SA, your insurer.

Data processing has been delegated to Groupe Mutuel Services SA (hereinafter: Groupe Mutuel), a company of Groupe Mutuel Holding SA. Both companies are subject to the Federal Law on Data Protection (LPD/DSG).

Personal data refers in particular to information relating to the persons concerned, which includes in particular information relating to the management of the insurance contract. Sensitive data refers in particular to information relating to the state of health of insured persons and to claims. The following categories of personal and sensitive data are mainly processed: declarative data of the persons concerned, i.e. data that Groupe Mutuel may collect from the persons concerned when expressing interest and/or subscribing to products and services that it provides or distributes; data relating to the services provided or to the operation of the products and services or their use, in particular when using online services; data coming from third parties, from other services or from public information when authorised.

Legal basis
Groupe Mutuel shall process the personal and sensitive data of the persons concerned and implement the processing operations according to the following legal grounds: the consent of the persons concerned, respectively the express consent for sensitive data; the legal provisions applicable to the activities of Groupe Mutuel (including the LPD/DSG); the contract concluded between Groupe Mutuel and the policyholder; the overriding public interest or the overriding private interest of Groupe Mutuel or the persons concerned, within the meaning of the LPD/DSG.

Purposes
Personal and sensitive data are used in particular to assess the risks to be insured, process claims, ensure the administrative, statistical and financial follow-up of the contract, allow the management of Groupe Mutuel's activities (statistics, internal and external audit, etc.) and compliance with its legal obligations, the improvement and development of services provided, the optimisation and cost-effectiveness of insurance costs, prospecting and marketing operations, the management of unpaid debts and disputes, the fight against fraud, money laundering, terrorist financing and tax fraud. To this end, this data may be communicated, pooled and exchanged between the Groupe Mutuel and third parties (see below). These exchanges are subject to contracts specifying the obligations and responsibilities of each party, or are based on a legal provision.

Profiling
In the course of their relationship with Groupe Mutuel, the persons concerned may be subject to marketing profiling so that the insurer can offer them services and products that correspond to their expectations, profile and needs. The details of such profiling are set out in the relevant data protection policy. Other types of profiling may take place for the purposes set out above.

Security
When personal data is processed, and with regard to the risks presented by data processing operations, Groupe Mutuel, its insurance intermediaries and other agents (for example a reinsurance company), undertake to take all necessary measures to comply with data protection law. These provisions include, in particular, the technical, physical and organisational measures required to safeguard the security of personal data and prevent its modification, damage or access by unauthorised third parties.

Data transfer
The data is treated confidentially and may be disclosed to third parties (e.g. insurance intermediaries, reinsurance companies, doctors, beneficiaries, disability insurance office (AI/IV), social security of the insured person's country of residence), including abroad. Disclosure of data takes place on the basis of legal obligations, court decisions, general insurance terms and conditions or the consent of the persons concerned. Consent must be express in the case of sensitive data. If the data processing operations are subject to a subcontracting, outsourcing or partnership contract with third parties, the latter shall undertake, as part of their contractual relationship with Groupe Mutuel, to comply with data protection law. Groupe Mutuel selects subcontractors who provide the necessary guarantees. The data entrusted to insurance intermediaries will be recorded and sent to Groupe Mutuel for the handling of insurance applications and for the administrative and financial follow-up between the insurance intermediary and the insurer. The latter is not responsible for the processing of personal data that the person concerned may have authorised from third parties or those that are carried out independently of Groupe Mutuel. It is up to the persons concerned to refer to the data protection policies of these third parties in order to check the terms and conditions of the processing operations carried out, or to exercise their rights with regard to these operations. To this end, this data may be communicated, pooled and exchanged between the Groupe Mutuel and third parties (see below). These exchanges are subject to contracts specifying the obligations and responsibilities of each party, or are based on a legal provision.

Storage period
Personal data is stored for as long as required by law, the management of the insurance contract, claims, recourse rights, debt recovery and/or any disputes between Groupe Mutuel, the insured, the insurance intermediary or third parties.

Rights of access and correction
The persons concerned have the right to access their personal data, to have their data corrected, to have their data deleted within the limits of the applicable legal provisions, to limit the processing of their data, to request that their data is transferred, to withdraw their consent to the processing of personal data, subject to the processing required for the performance of the contract, and to appeal to the competent supervisory authority.

Data Protection Officer
Groupe Mutuel has appointed a Data Protection Officer who can be contacted at the following address:
dataprotection@groupemutuel.ch. Further information on data protection is available on the Groupe Mutuel website: www.groupemutuel.ch