

Collective Accident Insurance (supplementing LAA/UVG coverage)

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Practical and legal information in accordance with the Federal Law on Insurance Contracts (LCA/VVG)

The following document for clients provides a clear and concise overview of the identity of the Insurer and the most important points of the insurance contract, as required by Article 3 of the Federal Law on Insurance Contracts (LCA/VVG).

Who is the Insurer?

The contractual partner is Groupe Mutuel Assurances GMA SA (hereafter «the Insurer»), whose headquarters are at Rue des Cèdres 5, P.O. Box, CH -1919 Martigny.

What risks are insured?

The insurance covers the economic consequences of occupational accidents, meaning all accidents within the meaning of the Federal Law on Compulsory Accident Insurance (LAA/UVG) incurred by an insured person in the scope of his gainful activity. All other accidents are considered non occupational accidents and also form an integral part of the insurance coverage.

The insurance also covers occupational illnesses. Occupational illnesses are defined as illnesses within the meaning of the LAA/UVG which qualify as occupational accidents from the day the employee is taken ill, from the first time he requires medical treatment or from the day he is unable to work.

What benefits are covered by the insurance?

Coverage may be extended to include the following benefits:

- treatment costs depending on the selected option (indemnity insurance);
- hospital daily allowance (fixed-sum insurance);
- daily allowance in case of incapacity for work (indemnity insurance);
- daily allowance in case of a relapse and/or late consequences from previous accidents which were not covered (indemnity insurance);
- daily allowance in the event of death within the limits of the entitlement to benefits of the LAA/UVG and the provisions of Article 338 of the Swiss Code of Obligations (fixed-sum insurance);
- in case of disability: a lump-sum disability benefit (fixed-sum insurance) and/or the cost of plastic surgery (fixed-sum insurance) and/or the cost of professional retraining (indemnity insurance);
- lump-sum benefit in case of death (fixed-sum insurance);
- benefits in the form of an LAA/UVG excess pension (indemnity insurance);
- coverage of the reduction imposed by the LAA/UVG accident insurance (indemnity insurance).

The scope of the insurance as well as any restrictions to it are set out in the General Terms and Conditions of Insurance.

What are the premium rates?

The premium rates depend on the insured benefits. Premiums are calculated based on premium rates and on the salaries reported by the employer.

Who is the policyholder and who are the insured persons?

The policyholder is the employer who concluded the insurance contract.

Insured persons may include:

- employees;
- the owner of a sole proprietorship and his/her family members if they are mentioned by name in the policy;
- the shareholders if mentioned in the policy.

Insurance policy:

The insurance policy specifies the insured persons, the amount of the maximum insured salary, the insured benefits and any special terms and conditions.

What are the obligations of the policyholder?

The obligations of the policyholder are set out in the insurance policy and in the General Terms and Conditions of Insurance. The policyholder must inform the insured persons of the main contents of this contract, of its amendments and termination, as well as of the possibility of maintaining insurance coverage in case of departure from the circle of insureds or upon expiry of the policy.

Furthermore, the policyholder must fulfill the following obligations:

- notify the Insurer promptly after hearing that one of his employees has had an accident which requires medical attention, causes an incapacity for work or results in the insured's death;
- notify the Insurer immediately of the termination of the employment relationship of an employee who has an incapacity for work;
- provide the Insurer with the salary declaration form for the final invoicing and, if requested, the insureds' AVS/AHV statements;

- afford the Insurer or the Insurer's agents access to the company's books and accounting information and to the documentation sent to the AVS/AHV Compensation Fund;
- provide any document capable of establishing the entitlement to benefits;
- notify the Insurer of any event likely to aggravate risks (e.g. change in corporate business activities or in the insured's profession).

The obligations of the policyholder are set out in the General Terms and Conditions of Insurance.

What are the obligations of the insured person?

The insured person must fulfill the following obligations:

- notify his employer or 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;

- consult a licensed doctor at his practice at the latest three days following the beginning of the incapacity and follow the doctor's instructions;
- cooperate with the Insurer and with social insurance institutions;
- make all efforts to limit damages;
- remain available for any necessary administrative or medical investigations during the period of incapacity for work;
- in case of fraud or insurance fraud attempts, the insured person shall pay for the investigation expenses incurred by the Insurer for the verification of the incapacity and follow-up of his case.

The obligations of the insured are set out in the General Terms and Conditions of Insurance.

Under what circumstances can the Insurer reduce or refuse insurance benefits?

The Insurer waives its rights to reduce its benefits for all accidents insured by the policy and caused recklessly or through gross negligence within the meaning of the LAA/UVG, subject to the exclusions provided for in the general terms and conditions of insurance.

Cash benefits will be reduced mutatis mutandis to the LAA/UVG insurance:

- when the accident was caused while committing an offence;
- in case of participation in brawls and fights;
- when the insured exposes himself to danger by seriously provoking a third party;
- if the insured participates in disturbances.

Benefits may be reduced or refused temporarily or definitively:

- if either the policyholder or the insured person does not respect his obligations;
- if the insured person refuses to comply with the Insurer's instructions or fails to appear for a medical examination requested by the Insurer;

- if the insured refuses to provide all information on the facts which could serve, to his knowledge, to determine the entitlement to benefits.

Any restrictions to benefits are set out in the General Terms and Conditions of Insurance.

When does the contract begin?

The contract is concluded once the Insurer has notified acceptance of the proposal.

The policy indicates the effective date.

When does the insurance contract end?

The contract expiry date is 31 December of a calendar year.

The policyholder can terminate the contract in the following cases:

- on expiry of the contract, subject to three months' notice; the notice of termination shall be deemed valid if it is received by the Insurer at the latest on 30 September. If the contract is not terminated, it shall be automatically extended for one year at a time.
- after each claim which a benefit is paid out for by the Insurer, at the latest 14 days after having become aware of the payment of the claim by the Insurer;
- if the Insurer changes the premiums; in this case, the notice of termination must reach the Insurer before the end of the calendar year.

The insurance also ends:

- if the company ceases its business activities;
- following non-payment of premiums;
- when the headquarters or the place of residence of the policyholder is transferred abroad.

In which case can the Insurer terminate the contract?

- upon expiry of the policy unless, the contract is terminated by the policyholder no later than on 30 September of the current calendar year.

If the contract is not terminated it shall be automatically extended for one year at a time;

- when the policyholder makes or attempts to make illegal profits causing the Insurer prejudice;
- the Insurer expressly waives his right conferred to him by the LCA/VVG to cancel the contract following loss or damage save in case of abuse, misrepresentation, fraud or non-disclosure, or attempted abuse, misrepresentation, fraud or non-disclosure by the policyholder.

These lists only contain the most common possible reasons for termination. The General Terms and Conditions of Insurance and the LCA/VVG contain other possible reasons.

When does the insurance coverage begin?

Coverage starts from the time the contract is effective but not before the first day of employment, or as soon as the entitlement to the first salary arises, and in any event from the moment the employee sets off to work.

When does the insurance coverage end?

For each insured person, insurance coverage ceases:

- if the insured person departs from the insurance contract:

at the end of the day before starting work with a new employer or registration to unemployment benefits, but at the latest at the end of the 31st day following termination of the employee's entitlement to at least half a salary; for part-time workers, who are insured only for occupational accidents and occupational illnesses, coverage ceases on the last day of work.

- following non-payment of premiums;
- at the end of the insurance contract;
- at the end of the LAA/UVG accident coverage for the worker posted abroad.

How does the Insurer handle data?

The insurer processes the personal and sensitive data of the policyholder and the insured persons, in particular data relating to the contract, collection of premiums and claims management, in accordance with the legal requirements for data protection.

Further details on data processing are set out in the Addendum to the General Terms and Conditions of Insurance.