

Group daily allowance insurance pursuant to LCA/VVG

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

The following information provides customers with a clear and concise overview of the identity of the insurer and of the most important points of the insurance contract, pursuant to 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 and what is the scope of the insurance coverage?

The insurer provides coverage of the economic consequences of incapacity due to illness.

Insurance coverage may extend to accident, leave due to childbirth, paternity leave or other risks as long as they are mentioned in the policy.

Insurance coverage relates to incapacity for work, i.e. the full or partial loss of the insured person's ability to perform the usual duties of the occupation practised, which may reasonably be required of him/her.

As soon as it is no longer possible to return to one's usual occupation, entitlement to benefits depends on the earning incapacity, i.e. any reduction in full or in part of the insured person's earning potential within a balanced labour market.

All claims for cases that occur during the term of the group insurance coverage shall be charged to the collective contract. Insurance coverage falls within the scope of damage insurance.

What benefits are insured?

The details of the insurance coverage, in particular the insured risks, the amount of the maximum salary taken into consideration for calculating the benefits, the percentage of the insured salary and the waiting period are set out in the policy and in any special terms and conditions.

The daily allowance benefit is granted proportionally to the degree of incapacity, which must be at least 25%.

From the time of payment of the AVS/AHV retirement pension, the insured person will be entitled to a maximum of 180 daily allowance benefits for one or more cases of incapacity for work.

The duration of benefits for insured persons with an employment contract of three months or less is limited to 90 days.

How is the premium calculated?

The premium is calculated based on the premium rates and the salaries declared by the employer. The premiums rates are based on the insured risks and agreed coverage.

Who is the policyholder and who are the insured persons?

The policyholder is the employer who concluded the insurance contract.

The circle of persons qualifying for insurance is mentioned in the policy.

What are the policyholder's obligations?

The policyholder's obligations are set out in the insurance policy and in the general terms and conditions of insurance. In particular, the policyholder is required to inform the insured persons of the main contents of this contract, its amendments and its termination.

The policyholder must also inform the insured persons about the possibility of maintaining insurance coverage when the employment relationship or the insurance contract is terminated. In addition, the policyholder is required to fulfil the following obligations:

- notify the insurer of incapacity for work cases within 15 days of occurrence;
- immediately inform the insurer of the end of the employment relationship with an employee who is unable to work;
- submit the salary declaration form to the insurer for the final invoicing and, on request, insured persons' AVS/AHV statements;
- authorise the insurer or designated third parties to inspect the company's books and accounts or the documents sent to the AVS/AHV compensation fund, if necessary;
- provide any document that may establish entitlement to benefits;
- notify the insurer of any event likely to increase the risk (e.g. change in the activities of the insured company or the insured person's occupation).

What are the obligations of the insured person?

The insured person is required to fulfil the following obligations:

- consult an authorised doctor at a medical practice at the latest within three days after the onset of the incapacity;
- provide any document that may establish entitlement to benefits;
- cooperate with the insurer and other social insurance institutions;
- undertake everything to reduce the damage;
- inform the insurer before undertaking a stay outside the vicinity of his/her home (radius of 200 km) during the period of incapacity for work;

In the event of fraud or attempted insurance fraud, the insured person shall pay for the investigation expenses incurred by the insurer for the verification of the incapacity as well as for the follow-up of the case.

The details of the obligations of the insured person are set out in the general terms and conditions of insurance.

Failure to comply with the obligations may lead to sanctions by the insurer, which may extend to the refusal of benefits.

In which cases can the insurer reduce or refuse insurance benefits?

Insurance coverage may be reduced or refused in the following cases (non-comprehensive list):

- if the policyholder or the insured person does not comply with the obligations set out in the terms and conditions of insurance;
- if the incapacity for work is not notified to the insurer within 15 days of its occurrence;
- if the initial certificate was issued more than three days after the onset of the incapacity;
- if the insured person refuses to cooperate with the insurer or other social insurance institutions;
- in the event of fraud or attempted insurance fraud;
- if the insured person fails to appear without good reason for a medical examination ordered by the insurer, the insurer may also request that any benefits already paid be refunded and may charge the insured person for the costs of the missed medical appointment;
- during a stay outside the vicinity of the insured person's home (radius of 200 km) in the cases provided for in the general terms and conditions of insurance;
- in the event of non-payment of premiums by the policyholder;
- if the incapacity is the result of voluntary plastic surgery not covered by the compulsory health insurance.

The details of the limitations of coverage are set out in the general terms and conditions of insurance.

When does the insurance contract begin?

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

When does the insurance contract end?

The policyholder may terminate the contract in the following cases:

- on the expiry of the contract as stated in the policy, subject to a notice period of three months. Termination is deemed to have been made in time if it reaches the insurer by 30 September at the latest. If the contract is not terminated, it shall be renewed automatically from year to year;
- after each claim for which a benefit is paid out, but at the latest within 14 days of becoming aware of the payment by the insurer;
- when the insurer increases the premiums. In this case, notice of termination must reach the insurer before the end of the calendar year.

The insurance also ends:

- when the insured company ceases its business activities;
- when the policyholder's registered office or place of residence is transferred abroad.

The insurer may terminate the contract in the following cases:

- on expiry of the contract as stated in the policy, subject to a notice period of three months. If the contract is not terminated, it shall be renewed automatically from year to year;
- if the policyholder failed to disclose or inaccurately disclosed an important fact;
- in the event of fraud or attempted insurance fraud by the policyholder.

These lists mention only the most common possible reasons for termination. Other possibilities are set out in the general terms and conditions of insurance and in the LCA/WVG.

When does insurance coverage begin?

For each insured employee, insurance coverage begins on the day of entry into force of the employment contract, but at the earliest on the effective date mentioned in the policy.

When does insurance coverage end?

For each insured person, insurance coverage ends:

- at the end of the employment contract, subject to an ongoing case of incapacity for work;
- in the event of non-payment of premiums;
- upon termination or suspension of the insurance contract;
- no later than the end of the month coinciding with the insured person's 70th birthday;
- at the end of the LAA/UVG accident coverage for workers posted abroad.

When does the entitlement to benefits end?

For each insured person, entitlement to benefits ends:

- upon suspension of the insurance contract due to non-payment of premiums;
- when the maximum entitlement to benefits is exhausted;
- no later than the end of the month coinciding with the insured person's 70th birthday;
- upon termination of the policy, subject to an ongoing case not being taken over by another insurer.

How is the data processed by the insurer?

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 general terms and conditions of insurance.

General terms and conditions for group daily allowance insurance pursuant to LCA/VVG

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A. General principles

Abbreviations

- LAVS/AHV: Federal Law on Old-Age and Survivors Insurance
LAI/IVG: Federal Law on Disability Insurance
LPP/BVG: Federal Law on Occupational Retirement, Survivors' and Disability Pension Plans
LAMal/KVG: Federal Law on Health Insurance
LAA/UVG: Federal Law on Accident Insurance
LAM/MVG: Federal Law on Military Insurance
LAPG/EOG: Federal Law on Compensation for Loss of Income

- LAFam/FamZG: Federal Law on Family Allowances
LACI/AVIG: Swiss Law on Compulsory Unemployment Insurance and Insolvency Benefits
LCA/VVG: Federal Law on Insurance Contracts
CO: Swiss Code of Obligations
CGA: General terms and conditions of insurance

Art. 1 Insurer

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

Art. 2 Purpose and type of insurance

1. Insurance coverage falls within the scope of damage insurance.
2. The insurer provides coverage of the economic consequences of incapacity due to illness. Insurance coverage may extend to accident, leave due to childbirth or other risks mentioned in the policy.

Art. 3 Legal bases of the contract

The contract is based on:

1. These general terms and conditions of insurance (CGA), any additional special terms and conditions of insurance, the policy and any addendums thereto.
2. The clauses and statements specified in the insurance proposal and in any other statements of the policyholder and the insured persons, as well as the health questionnaires.
3. LCA/VVG
4. The Code of Obligations (CO).

Art. 4 Definitions

1. Health impairment

“Health impairment” encompasses illness and/or accident.

2. Illness

Illness means any medically and objectively detectable, involuntary impairment of the insured person’s physical, mental or psychological health that is not the result of an accident or its consequences, and that requires medical examination or medical treatment, or which results in incapacity. Pregnancy complications are equated with an illness.

3. Accident

Accident means any harmful, sudden and involuntary, medically and objectively detectable, injury to the human body which is prejudicial to physical, mental or psychological health or results in death and was occasioned by an extraordinary external cause. Are also equated with accidents, sequels and relapses from accidents, bodily injuries equated with accidents as well as occupational illnesses within the meaning of the LAA/UVG.

4. Incapacity

Unless otherwise provided, incapacity is both incapacity for work and earning incapacity.

5. Incapacity for work

Incapacity for work refers to the loss, in whole or in part, of the insured person’s ability to perform the usual duties of the occupation practised, which may reasonably be required of him/her, if the loss results from an impairment to his/her physical, mental or psychological health. As soon as the resumption of the usual occupation is no longer possible, entitlement to benefits depends on the incapacity for work.

6. Earning incapacity

- a. Earning incapacity means any reduction, in full or in part, of an insured person’s earning potential within a balanced labour market.
- b. Only the medical limitations due to the health impairment are taken into account to assess the existence of an earning incapacity.
- c. Earning incapacity is determined by the difference between the income earned before the incapacity for work in one’s previous occupation and the average income which, from a medical point of view, could be earned in another activity,

taking into account the level of competency of the insured person, according to the existing Swiss Earnings Structure Survey (ESS).

7. Insurance case

An insured case is defined as a disability caused by one or more health impairments, which may occur during the same period of disability.

8. Relapse

A relapse is considered to be an incapacity that is medical-ly related to a previous incapacity and that occurs during the period of coverage and during the 365 days following the end of the previous incapacity. Under these conditions, the relapse belongs to the same insurance case as the previous incapacity.

B. Scope of insurance

Art. 5 Insurance policy

The insurance policy sets out the details of the insurance coverage, including the insured risks, the amount of the maximum salary considered for calculating the benefits, the percentage of the insured salary, the waiting period, the duration of benefits and any special terms and conditions.

Art. 6 Insured persons

1. The circle of persons qualifying for insurance is mentioned in the policy.
2. A person who is fully or partially unable to work when the policy comes into force, or at the beginning of the employment relationship, is not insured. This person will be covered as soon as he/she has recovered full capacity for work. The agreement regulating the free transfer of coverage is reserved.
3. A person who is receiving a disability pension at the time the policy comes into force or at the beginning of the employment relationship is insured for the salary received from his/her residual capacity for work, from which the insured person can take advantage substantially and permanently.
4. A person whose employment contract is terminated during the incapacity entitling him/her to benefits shall continue to be part of the circle of persons qualifying for insurance until the end of the said ongoing incapacity. The agreement regulating the free transfer of coverage is reserved.

Art. 7 Start and end of insurance contract

1. The entry into force of the contract and its expiry date are mentioned in the policy.
2. When the policy expires and unless notice of termination is received by 30 September at the latest, the contract will be automatically renewed from year to year.
3. The contract ends:
 - a. in the event of termination by the policyholder or by the insurer;
 - b. if the insured company ceases its business activities;
 - c. if the contract is terminated in the event of a claim, in accordance with Art. 8 of these general terms and conditions of insurance;
 - d. if the contract is terminated in the event of a fraudulent claim, in accordance with Art. 9 of these general

- terms and conditions of insurance;
- e. in the event of non-payment of premiums, in accordance with Art. 33, para. 5 of these general terms and conditions of insurance;
- f. if the policyholder's registered office or place of residence is transferred abroad;
- g. in the event of termination as a result of a premium increase within the meaning of Art. 34 of these general terms and conditions of insurance.

Art. 8 Termination following a claim

1. After each claim for which a benefit is payable by the insurer, the policyholder is entitled to withdraw from the contract no later than 14 days after having become aware of the payment of the benefit. If the policyholder withdraws from the contract, the insurance ceases to be effective 14 days after the notice of termination has been sent to the insurer.
2. The insurer expressly waives its right under the LCA/VVG to withdraw from the contract in the event of a claim, save in case of abuse, misrepresentation, fraud or non-disclosure, or attempted abuse, misrepresentation, fraud or non-disclosure pursuant to the LCA/VVG.

Art. 9 Fraudulent claim

The policy may be cancelled or terminated when the policyholder makes or attempts to make illegal profits causing prejudice to the insurer.

C. Insurance coverage

Art. 10 Beginning of the insurance coverage

For each insured person, insurance coverage begins on the day of entry into force of the employment contract, but at the earliest on the effective date mentioned in the policy.

Art. 11 End of insurance coverage

For each insured person, insurance coverage ends:

- a. at the end of the employment contract, subject to the provisions of Art. 17 of these general terms and conditions of insurance;
- b. in the event of non-payment of premiums in accordance with Art. 33 of these general terms and conditions of insurance;
- c. at the end of the insurance contract or upon suspension;
- d. no later than the end of the month coinciding with the insured person's 70th birthday;
- e. at the end of the LAA/UVG accident coverage for the worker posted abroad.

Art. 12 Transfer to individual insurance

1. A Swiss resident who ceases to belong to the circle of persons qualifying for insurance has the right to maintain insurance coverage on an individual basis, without a new medical exclusion. The insured person must assert the right within 90 days of leaving the circle of persons qualifying for insurance.
2. A cross-border worker who no longer belongs to the cir-

cle of insured persons shall be entitled to maintain coverage on an individual basis without a new medical exclusion being pronounced, if the person continues to be employed in Switzerland. The insured person must assert the right to transfer within 90 days of leaving the circle of persons qualifying for insurance.

3. At the time of the transfer, the prevailing general terms and conditions for individual insurance will apply. The daily allowance will be reduced proportionally if the amount of the new income or unemployment benefit is lower.
4. The age of the insured person at the time of joining the group contract is decisive in calculating the premium.
5. There is no entitlement to transfer to individual coverage in the following cases:
 - a. if the insurance contract is terminated and transferred to another insurer for the same circle of persons qualifying for insurance, or parts thereof;
 - b. for self-employed individuals, employers and their family members who are not subject to AVS/AHV contributions;
 - c. for persons with a fixed-term employment contract of three months or less, and for temporary staff employed on an occasional basis;
 - d. if the insured person leaves his/her job and transfers to the daily allowance insurance plan of a new employer;
 - e. for persons who have reached AVS/AHV retirement age or who have retired.

D. Benefits

Art. 13 Entitlement to benefits

1. An insured person who is unable to work is entitled to insured benefits only if he/she suffers a loss of salary/earnings as a result of a health impairment.
2. As soon as it is no longer possible to return to one's usual occupation, entitlement to benefits depends on the incapacity for work.
3. Only incapacity and a possible relapse that may occur during the period of insurance coverage give entitlement to benefits. The agreement regulating free transfer of coverage remains reserved.

4. Partial incapacity

- a. The daily allowance is granted in proportion to the degree of disability, which must be at least 25%.
- b. Days of incapacity below this rate are not taken into account when calculating the duration of benefits and the waiting period.
- c. Days of partial disability greater than or equal to this rate are counted as full days for calculating the duration of the benefits and the waiting period.

5. Notification of incapacity

- a. Each incapacity of at least 25% must be notified to the insurer within 15 days of its occurrence. After this time limit, the day of receipt of the notification by the insurer is deemed to be the first day of incapacity.
- b. If the notification was made late for excusable reasons, the payment of daily allowance benefits will be limited to 180 days preceding the day of the notification.

6. Medical certificate of incapacity

- a. If the initial certificate was issued more than three

days after the onset of the incapacity, the insurer reserves the right to consider the date of issuance of the certificate as the first day of incapacity.

- b. The insurer pays for medically certified and proven incapacity. If the incapacity for work lasts more than three days, a medical certificate is mandatory. A doctor's certificate, based on regular medical visits, must be sent to the insurer at least once a month.

7. Waiting period

- a. The daily allowance due is payable on expiry of the agreed waiting period, for each day of incapacity (Sundays and public holidays included).
- b. If the waiting period per incapacity is provided for in the policy, it applies to each case of incapacity giving rise to benefits. In case of a relapse, only the possible residual waiting period will be applied.
- c. If the policy provides for a waiting period per calendar year, it will apply once per calendar year for one or several cases of incapacity entitling to benefits. In case of an uninterrupted case of incapacity over several years, the waiting period will apply only once.
- d. If the policy provides for a waiting period per year of employment, it will apply once per calendar year for one or more cases of incapacity entitling to benefits. In case of an uninterrupted case of incapacity over several years of employment, the annual waiting period will apply only once. A year of employment is a period of 365 consecutive days during which a working relationship exists with the policyholder.
- e. When the ongoing incapacity is no longer the result of an accident but of an illness, or vice versa, the waiting period will apply to the new risk (accident, illness), except when both risks are covered by the same insurer.
- f. The waiting period will be deducted from the term of entitlement to benefits.

Art. 14 Benefits when receiving an AVS/AHV retirement pension

From the time of payment of the AVS/AHV retirement pension, the insured person will be entitled to a maximum of 180 daily allowance benefits for one or more cases of incapacity for work. If a case of incapacity began before the payment of the AHV/AVS pension, the entitlement to benefits is limited to the remaining benefits provided for in the policy, but up to a maximum of 180 days, provided that the continuation of the employment contract was decided before the incapacity.

Art. 15 Benefits in the event of an employment contract of three months or less

The duration of benefits for insured persons with an employment contract of three months or less is limited to 90 days.

Art. 16 End of entitlement to benefits

For each insured person, entitlement to benefits ends:

- a. on suspension of the insurance coverage due to non-payment of premiums;
- b. when the maximum entitlement to benefits is exhausted;
- c. at the end of the month coinciding with the insured person's 70th birthday;

- d. upon termination of the insurance contract, subject to the ongoing case not being taken over by another insurer.

Art. 17 Ongoing incapacity at the end of the employment contract

1. Insurance coverage and entitlement to benefits shall be maintained for the ongoing incapacity at the end of the insurance contract.
2. The incapacity that gave rise to the entitlement to benefits shall be charged to the group contract.
3. The agreement regulating free transfer of coverage remains reserved.

Art. 18 Exhaustion of benefits

1. Impairments related to a case in respect of which benefits have been exhausted are no longer covered and there is no entitlement to benefits, subject to the provisions of Art. 29 of these general terms and conditions of insurance (Additional loss of earnings coverage).
2. The insured person cannot prevent the exhaustion of the entitlement to daily allowance benefits by renouncing his/her right to daily allowance insurance. In this case, the insurer shall pay benefits based on the assessment of the incapacity by the medical advisor.

Art 19 Calculation of the daily allowance

1. The AVS/AHV salary due by the insured company shall form the basis for calculating the daily allowance. The salary and part of the salary not subject to the AVS/AHV due to the age of the insured person, as well as family allowances as soon as they are no longer received by a beneficiary, are also taken into account.
2. For those parts of the salary subject to AVS/AHV which have not yet been paid at the time of the incapacity and to which the person may be entitled, the corresponding daily allowance is calculated by dividing by 365 the said elements received during the 12 months preceding the incapacity, but at the earliest from the date of starting employment.
3. An increase in salary during an incapacity can be taken into account if it was agreed prior to the incapacity or if it is provided for by a collective labour agreement.
4. If the allowance is expressed as a percentage of the salary, it is calculated for hourly and monthly salaries, but up to the maximum ceiling provided for in the collective agreement, as follows:

Hourly salary:

Gross base hourly salary (including 13th month if applicable):
multiplied by:
average number of weekly or annual hours multiplied by:
52 weeks (for hours on a weekly basis) divided by:
365 days (including leap year) multiplied by:
fixed percentage of coverage.

With this method, additional amounts for paid holidays and public holidays are included in the calculation of the daily allowance. The gross basic hourly wage does not include holidays and public holidays, which are not added to the basic hourly wage.

Monthly salary:

Monthly salary multiplied by:

12 months (or 13 months, if a 13th salary is paid) divided by:
365 days (including leap year) multiplied by:
fixed percentage of coverage.

5. If the insured person is employed on an irregular basis or if the salary is subject to significant fluctuations, the daily allowance is calculated by dividing by 365 the salary received during the 12 months prior to the incapacity.

Art. 20 Unpaid leave

1. During unpaid leave, coverage is maintained for a maximum of 12 months.
2. The waiting period begins on the first day of incapacity. The entitlement to benefits begins at the earliest on the day the employee is scheduled to return to work.

Art. 21 Benefits in the event of death

In the event of the death of the insured person resulting from the incapacity entitling him/her to benefits, the insurer shall pay the policyholder the daily allowance within the limits of the entitlement to benefits and the provisions of Article 338 of the Swiss Code of Obligations.

Art. 22 Benefits for the care of children with a serious medical condition

1. In the event of leave in order to care for a child with a serious medical condition, the insurer will supplement the daily allowance paid by the LAPG/EOG up to the maximum insured benefits.
2. The benefit is subject to the entitlement to benefits under the LAPG/EOG and is paid for the same duration.

Art. 23 Benefits outside the vicinity of the home

1. Pursuant to Art. 38, para. 1 of these general terms and conditions of insurance:
 - a. If an incapacity for work occurs outside the vicinity of the insured person's home (radius of 200 km), the insured person is entitled to benefits as long as the person can prove that a return is medically not possible, in particular during the period of hospitalisation.
 - b. During an incapacity, the insured person who wishes to leave the vicinity of his/her home (radius of 200 km) must inform the insurer prior to departure. After analysing the circumstances, the insurer may decide to keep granting daily allowance benefits for a limited period. In the absence of an agreement with the insurer, benefits will be refused during the stay outside the vicinity of the home.
2. The worker posted abroad is entitled to benefits as long as he/she remains covered under the terms of the LAA/UVG and then as soon as the person returns to Switzerland.

Art. 24 Incapacity due to negligence

The insurer waives its right under the LCA/VVG to reduce benefits for illnesses caused by gross negligence of the insured person.

Art. 25 Limitation of entitlement to benefits

1. Benefits will be refused:
 - a. if there is a medical exclusion or in case of non-disclosure;
 - b. if the incapacity is the result of voluntary plastic surgery not covered by the compulsory health insurance;
 - c. in case of incapacity due to earthquakes;
 - d. in case of incapacity due to events of war:
 - in Switzerland;
 - abroad, unless events caught the insured person by surprise in the country where he/she was staying and provided the incapacity occurs no later than three months after the start of these events;
 - e. in case of fraud or attempted insurance fraud;
 - f. for health damage caused by ionising rays and damage caused by nuclear radiation, except for health impairments resulting from medical treatment;
 - g. in case of incapacity during military service abroad.
2. Benefits may be reduced or refused temporarily or permanently:
 - a. if the accident is caused by the fault of the insured person, in the event of extraordinary dangers or hazardous activities within the meaning of the LAA/UVG;
 - b. if the policyholder or the insured person does not comply with the obligations under Articles 37 and 38 of these general terms and conditions of insurance;
 - c. if the insured person refuses to comply with the insurers' investigation measures (e.g. be examined by a doctor appointed by the insurer) or fails to appear for a medical examination ordered by the insurer without good reason. In this case, the insurer also reserves the right to demand that any benefits already paid be refunded and to charge the insured person for the costs of the missed medical appointment;
 - d. if the insured person refuses to provide all information on the facts known to him/her that could serve to determine entitlement to benefits;
 - e. if the insured person fails to submit an application for benefits to the AI/IV disability insurance, or does not do so in good time. In this case, daily allowance benefits will be suspended until the date the claim is filed.
3. During periods of suspension for non-payment of premiums as defined in Art. 33 of these general terms and conditions of insurance:
 - Claims that occur are not covered.
 - For ongoing claims, payment will resume once the premium arrears have been paid. In this case, the days of incapacity will be deducted from the duration of entitlement to benefits.
4. Entitlement to benefits is suspended as long as the insured person is receiving benefits from the federal maternity insurance under the LAPG/EOG or the cantonal maternity insurance.

If the insured person is not receiving benefits from the federal maternity insurance under the LAPG/EOG or the cantonal maternity insurance, the entitlement to benefits is suspended for 56 days after the birth if the pregnancy lasted at least 23 weeks. Article 26 of these general terms and conditions of insurance remains reserved.

E. Supplemental benefits

Art. 26 Maternity allowance benefits

1. This coverage is granted if it is included in the policy.
2. The maternity allowance benefit is subject to entitlement to federal benefits under the LAPG/EOG or cantonal benefits.
3. If payment of federal benefits under the LAPG/EOG or cantonal benefits is extended in the event of hospitalisation of the newborn child, the payment of the maternity allowance benefit is also extended for an equivalent period.
4. Federal benefits under the LAPG/EOG and/or cantonal benefits are deducted from the amount to be paid by the insurer.

Art. 27 Paternity allowance benefits

1. This coverage is granted if it is included in the policy.
2. The paternity allowance benefit is subject to entitlement to federal benefits under the LAPG/EOG or cantonal benefits.
3. Federal benefits under the LAPG/EOG and/or cantonal benefits are deducted from the amount to be paid by the insurer.

Art. 28 Benefits in the event of adoption

1. If the supplemental benefit in case of maternity and/or paternity is provided for in the policy, it is also granted in case of adoption provided that benefits according to federal or cantonal regulations are also granted.
2. The adoption of the child of the insured person's spouse does not give rise to entitlement to benefits.

Art. 29 Additional loss of earnings coverage

1. If it is included in the policy, "additional loss of earnings" covers the salary obtained through the insured person's capacity for work which is useful to the company, substantially and permanently, in cases where the entitlement to benefits has been exhausted.

The insured person will then be entitled to a new coverage of 180 days within a period of five years starting from the date of exhaustion of the benefits.

2. The waiting period applies to each case of incapacity but is not deducted from the 180-day term.
3. An employee cannot be entitled to benefits under the additional coverage more than once.
4. If, at the end of the five-year period running from the start of extended coverage, the insured person has not exhausted the term of entitlement to benefits under the said coverage, the insured person will once again be entitled to the main coverage.
5. Additional loss of earnings coverage will be strictly related to the group insurance contract of the company with a view to promoting professional rehabilitation. The employee who ceases to belong to the circle of persons qualifying for insurance will not be entitled to free transfer for this benefit.

F. Coordination of benefits

Art. 30 Third party benefits

1. The insurer subsidiarily covers the insured person's loss of salary or loss of earning, which are not covered by any other social or private insurer.

2. If a third party reduces its benefits due to a sanction, the insurer shall not compensate the ensuing reduction.
3. If several private insurers cover the insured person's loss of salary/earnings, the aggregate benefits paid by them cannot exceed the loss suffered. In this case, the insurer will compensate the loss of earnings or loss of salary benefits pro rata to the insured daily allowance proportionately to the share of the total insured benefits.
4. Upon occurrence of the insured risk, the insurer is subrogated, within the limits of the contractual benefits, to the rights of the insured person and his/her survivors against any liable third party.
5. If the insured person concludes an agreement, without the insurer's consent, by virtue of which the insured person fully or partially renounces the benefits or compensation due from a third party liable for benefits, the insurer's contractual benefits will be reduced accordingly.
6. Within the limits of the entitlement to benefits, the insurer shall continue to pay benefits in advance until the Federal Disability Insurance (LAI/IVG), accident insurance (LAA/UVG), military insurance (LAM/MVG), a pension fund (LPP/BVG) or a foreign or private insurer establishes that the insured person is entitled to a pension. As soon as a pension is granted by one or more of the aforesaid institutions, the insurer shall be entitled to request reimbursement of the advances granted directly from the latter or from another third party. The repaid amount shall vest with the insurer.
7. For the purpose of calculating the duration of benefits, days on which benefits are reduced or on which the insurer is not required to pay benefits due to third party benefits, will count as full days.
8. With particular reference to free transfer agreements, the period during which daily allowances benefits were paid by previous insurers shall be deducted from the maximum duration of the entitlement to benefits under the group insurance plan.

Art. 31 Excess benefits

The benefits payable by the insurer, or the conjunction of such benefits with those paid by other insurers, must not result in excess benefits for the insured person. Excess benefits, i.e. the portion of the daily allowance paid that is greater than the actual loss of salary/earnings or, at most the benefits provided for in the policy, shall be offset against current benefits or shall be repaid to the insurer.

G. Premiums

Art. 32 Calculation of the premium

The AVS/AHV salary owed by the insured company forms the basis for calculating the premium. The salary and portion of salary not subject to the AVS/AHV due to the age of the insured person, as well as family allowances, are also taken into account.

Art. 33 Payment of premiums

1. The policyholder is the debtor of the premiums.
2. The premium is due within the time limit specified in the policy.
3. Premium instalments due during a calendar year of insurance shall be considered as instalments to be paid within the relevant time limits. They may be adjusted at any time to allow for payroll changes during the year.

4. If the premium or premium instalments are not paid in time, 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 the premium arrears and costs are not paid within the time limit, the insurer's obligations shall be suspended on expiry of the time limit.
5. 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 terminated.

Art. 34 Adjustment of premium rates

1. Unless specifically agreed in the policy, the insurer may adjust the premium each year to allow for trends in claims or if premium rates are changed. Premiums shall be adjusted as of 1 January of each year. The insurer shall inform the policyholder of the new premium rate no later than 25 days before the end of the current year. In the event of a premium rate increase, the policyholder may exercise a right of termination before the end of the calendar year (date of receipt by the insurer).
2. The premium rate may be adjusted when new circumstances come into force (e.g. change in the company's activity, merger, spin-off, takeover) or in the event of restructuring, provided that the payroll varies by 10% or more. In the event of an increase in the premium rate, the policyholder may exercise a right of termination within 30 days from the date of notification (date of receipt by the insurer).

Art. 35 Premium statement

The final premium statement is drawn up at the end of the financial year corresponding to the calendar year, based on the documents provided by the policyholder in accordance with Article 37 of these general terms and conditions of insurance.

Art. 36 Surplus sharing

1. If provided for in the policy, the policyholder will receive a share of any surplus premiums.
2. The settlement is made at the earliest five months after the end of the settlement period, provided the premiums for this period have been paid in full.
3. The benefits paid for the accounting period are deducted from the relevant part of the premiums paid in accordance with the provisions of the policy. If there is a surplus, the policyholder receives the share agreed in the policy.
4. If the insurance policy is terminated for the end of a surplus sharing accounting period, the calculation of the surplus sharing is postponed until the end of all the cases of incapacity for work covered by the group insurance contract. Benefits paid after termination are also included in this calculation.
5. If the claims for a closed accounting period are announced or compensated after the accounting statement has been drawn up, a new surplus sharing statement will be drawn up. The insurer shall demand that any surplus sharing payments made be returned.
6. Any surplus sharing amounts shall be paid provided the insurance policy remains in force until the end of the accounting period.
7. Only the premiums and benefits relating to daily allowance benefits in the event of illness and accident are taken into account in the surplus sharing calculations.

H. Obligations

Art. 37 Obligations of the policyholder

1. The policyholder is required to inform the insured person of his/her rights and obligations arising from the insurance, in particular the possibility of maintaining insurance coverage when the employment relationship or the insurance contract expires.
2. Pursuant to the duty to inform (Article 3 LCA/VVG), the policyholder is also required to inform the insured person about the essential elements of the contract.
3. The policyholder must inform the insurer of each incapacity for work, in accordance with Art. 13, para. 5 of these general terms and conditions of insurance.
4. The policyholder shall immediately notify the insurer whenever the employment relationship with an employee who has an incapacity for work is terminated.
5. For the final invoicing, the policyholder shall provide the insurer with the salary declaration form and, if requested, the AVS/AHV statements of the insured persons. If the salary declaration form is not provided within 30 days of the insurer's request, the insurer shall send a formal notice to the policyholder. If the formal notice remains without effect, the insurer will automatically charge the policyholder by increasing the annual premium for the previous year. Article 33 of these general terms and conditions applies mutatis mutandis to the payment of the supplemental premium.
6. The policyholder is required to authorise the insurer, or appointed third parties, to access the company's books and accounting records or the documents sent to the AVS/AHV compensation fund, failing which the insurer reserves the right to suspend its obligations.
7. The policyholder undertakes to provide the insurer, automatically or on request, with any document that may establish entitlement to benefits (power of attorney, medical certificates, accounting or administrative documentation, etc.). The insurer reserves the right to check the plausibility of the declared salary.
8. The policyholder must inform the insurer of any increase in risk (e.g. change in the company activity or insured occupation).
9. Failure to comply with these obligations may result in sanctions by the insurer, which may include the refusal of benefits, pursuant to Art. 25 of these general terms and conditions of insurance.

Art. 38 Obligations of the insured person

1. During the period of incapacity, the insured person must remain available for any necessary administrative or medical investigations by the insurer (such as be examined by a doctor appointed by the insurer).
2. The insured person will provide the insurer, automatically or at the insurer's request, with any document that may establish entitlement to benefits (power of attorney, medical certificates, decision and/or statement of benefits from other insurers, etc.). The insured person shall also notify the insurer immediately of any changes in circumstances that may affect entitlement to benefits (change in the degree of incapacity, registration to the unemploy-

- ment insurance fund, entitlement to third party benefits, etc.).
3. The insured person shall release his/her doctors from medical and professional secrecy vis à vis the insurer's medical advisor.
 4. The insured person must cooperate with the insurer and with the third parties appointed by the insurer (claims inspector, officers, doctors, etc.). In particular, the insured person must follow their instructions, provide the requested documents and answer, fully and truthfully, any questions asked by the insurer.
 5. The insured person must file a claim for benefits with the AI/IV disability insurance within six months from the beginning of the incapacity or, upon request of the insurer, with another social institution.
 6. The insured person is obliged to limit damages, including cooperate with social insurance institutions (disability insurance, accident insurance, military insurance, etc.).
 7. Within reasonable limits, the insured person shall participate in treatment or in professional rehabilitation measures designed to significantly improve capacity for work or offer new earning prospects.
 8. At the latest three days following the beginning of the incapacity, the insured person shall consult a licensed doctor at his/her practice and follow the instructions given.
 9. Non-compliance with these obligations may lead to sanctions by the insurer, which may extend to the refusal of benefits, pursuant to Art. 25 of these general terms and conditions of insurance.
 10. 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 as well as for the follow-up of the case.

I. Other provisions

Art. 39 Assignment and pledging of benefits

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

Art. 40 Broker clause

The policyholder may appoint a broker to conduct the business relationship with the insurer. In this case, information is considered to have reached the policyholder once it has reached the broker.

Art. 41 Notices

1. All notices must be sent to the postal or electronic addresses indicated on the insurer's official documents or by any other means made available by the insurer, excepted social networks.
2. Notices made by the insurer are valid if they are sent to the last postal or electronic address communicated to the insurer by the policyholder or the insured person. These notices may be sent by other means made available by the insurer.

Art. 42 Place of performance

Save any special provisions to the contrary, the obligations arising from the contract shall be performed in Switzerland and in Swiss francs.

Art. 43 Jurisdiction

In case of a dispute, the policyholder, insured person or beneficiary may choose the jurisdiction of the courts of his/her place of residence in Switzerland, or of the insurer's headquarters or, if the insured person is domiciled abroad, that of his/her place of work in Switzerland.

Art. 44 Data protection

Personal and sensitive data

Your insurer Groupe Mutuel Assurances GMA SA has requested that Groupe Mutuel Services SA (hereafter: Groupe Mutuel) processes the personal and sensitive data of the policyholder, the insured persons, and where applicable, their beneficiaries or related persons (hereinafter: persons concerned). Groupe Mutuel Assurances GMA SA and Groupe Mutuel Services SA are companies of Groupe Mutuel Holding SA. They are subject to the Federal Law on Data Protection (LPD/DSG).

Personal data refers in particular to information relating to the concerned person, including 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 claims.

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.

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 (e.g. 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

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 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.

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 person, 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