

General terms and conditions for supplemental health and accident insurance of Groupe Mutuel Assurances GMA SA

Note: in this document, any use of the masculine form applies to both males and females.

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The insurer is Groupe Mutuel Assurances GMA SA.

Art. 1 Individual insurance contract per product; bases of insurance contract

1. Unless otherwise stipulated in the terms and conditions of insurance, the insurance contract is subject to the Federal Law of 2 April 1908 on Insurance Contracts (LCA/VVG).
2. The insurance proposal, the insurance policy, these general terms and conditions (CGC) the special terms and conditions of insurance and any special agreements constitute the bases of the insurance contract.
3. A separate, individual contract will be concluded in respect of each insurance product regulated by the corresponding special terms and conditions.

Art. 2 Purpose of insurance

1. In principle, the insurance covers the economic consequences of illness, maternity and accident.
2. The special terms and conditions for each insurance product define the insured risks.

Art. 3 Definitions

1. Illness means any impairment of the insured person's physical, mental or psychological health which is not the result of an accident, requires medical examination or medical treatment, or causes incapacity for work.
2. Accident means any damaging, sudden and involuntary injury to the human body which is prejudicial to physical,

mental or psychological health and was occasioned by an extraordinary external cause.

Bodily injury within the meaning of Art. 6 para. 2 of the Federal Law on Accident Insurance (LAA/UVG) are considered as accidents.

3. Maternity includes pregnancy, childbirth and postnatal recovery.

Art. 3a Type of insurance

1. Unless otherwise provided in the special terms and conditions of insurance, the coverage of products governed by these general terms and conditions falls within the scope of indemnity insurance.
2. Insurance coverage within the scope of indemnity insurance shall compensate for the actual loss suffered up to the amount of the insured benefits.
3. In the event of a claim, insurance coverage that falls within the scope of fixed-sum insurance provides for the payment of the sum specified in the policy, regardless of the actual loss suffered.

Art. 4 Territorial validity

1. Coverage is valid worldwide.
2. If an insured person falls sick or has an accident in Switzerland and seeks medical treatment elsewhere, the cost of such treatment will only be reimbursed if the policyholder or the attending doctor submits an application to the insurer in advance and the insurer accepts it.

Art. 4a Continuation of insurance coverage in the event of a transfer of residence abroad

1. Unless otherwise stipulated in the special terms and conditions of insurance, insurance products may be retained if the insured person moves abroad during the term of the contract, without any increase in insurance coverage, provided that the insured person remains subject to compulsory health insurance under the LAMal/KVG in accordance with the Agreement on the Free Movement of Persons between the EU and EFTA or other international social security agreements, or is covered by equivalent insurance in accordance with Art. 7a of the Swiss Ordinance on Health Insurance (OAMal/KVV).
2. The insured person residing abroad must notify the insurer in writing within 30 days when he no longer complies with the criteria specified in Art. 4a, para. 1 of these terms and conditions of insurance. In the event of a breach of this obligation, the insured person must reimburse to the insurer any benefits paid from the date on which the above criteria were no longer fulfilled.

Art. 5 Applicant, policyholder and insured person

1. The applicant is the person who submits an application for an insurance contract to the insurer.
2. The policyholder is the person who has concluded a contract with the insurer.
3. The person who is mentioned as insured in the insurance policy is considered to be the insured person.

Art. 6 Insurance proposal

1. When an insurance proposal is sent, this is not a request for an offer; it constitutes a formal declaration of the applicant's intent to take out one or more insurance contracts. The applicant remains bound to the insurer in accordance with the provisions of Art. 1 LCA/ VVG, i.e. for 14 days, or four weeks if medical information is required.
2. The applicant may cancel the application within 14 days of the application to take out the contract. This deadline is met if the applicant submits the cancellation to the insurer in accordance with Art. 37 of the general terms and conditions of insurance, or if he submits the notice of cancellation to the post office by the last day of the deadline.
3. If the proposal comes from the insurer, the policyholder may cancel the contract within 14 days of its acceptance by the policyholder.
4. The insurance proposal can be made using the form made available by the insurer. The applicant must answer all the questions on the insurance application, as well as in the health questionnaire, completely and truthfully. The applicant is responsible for ensuring that the answers given by a third party or by an intermediary are in accordance with his instructions. Insured persons must authorise third parties to provide the insurer with any documents and information it may require.
5. The insurer reserves the right to accept or refuse the insurance proposal, to issue medical exclusions or to apply higher premiums if the special terms and conditions of the product so require. The insurer is not obliged to give reasons for its decision.
6. The refusal of one or several products in the insurance application, or any medical exclusions issued for one or several products, does not justify the withdrawal from other products accepted by the insurer.
7. The refusal of products for other family members (spouse, children), or any other medical exclusions issued for other family members, does not justify withdrawal from the applicant's own application or contract(s).
8. The insurance application of a person who does not have the right to exercise civil rights must be ratified by his legal representative.

Art. 7 Medical information

1. The insurer may demand to have a medical report issued at its expense.
2. It can also require that the applicant undergoes a medical examination by a doctor designated by the insurer.

Art. 8 Restrictions

1. If a person is suffering from an illness or from the sequels of an accident when he files the insurance proposal, the insurer is entitled to restrict coverage for that illness or accident. Coverage may also be restricted for previous illnesses or accidents suffered by the insured person if experience shows that relapses are possible.
2. The ailment subject to the medical exclusion is communicated to the insured person by means of a declaration of consent. The insured person who agrees to conclude the contract that includes the medical exclusion is obliged to

give his consent. If the insured person does not agree within the time limit set by the insurer, the insurer may consider that the insured person is waiving his right to conclude the coverage subject to the medical exclusion.

3. Medical exclusions are valid for the entire duration of the contract. An insured person may have a certificate issued at his cost certifying that an exclusion is no longer justified. In that case, the insurer is entitled to maintain or cancel the exclusion.

Art. 9 Changes to the insurance coverage

1. A proposal to increase the insurance coverage (e.g. reduce the deductible amount, increase the level of coverage or the insured lump-sum) within the same product is regarded as a proposal for a new insurance contract within the meaning of Art. 6 to 13 of these general terms and conditions of insurance.
2. The insurer reserves the right to accept or refuse the proposal or to decide restrictions in compliance with the conditions and time limits set out in Art. 1 LCA/VVG and Art. 6 of these general terms and conditions. In particular, the terms and conditions of the contract, such as the termination notice period and a possible non-availability period (initial period of the contract during which insurance coverage is not acquired for all or certain benefits), shall apply again, and no acquired rights can be taken over from the old contract.
3. A reduction in coverage within the same product is only possible after the minimum contract term has expired, subject to one month's notice to the end of a calendar year. If the request for a reduction in coverage is made following a premium increase, only one month's notice for the end of a calendar year is required.

Art. 10 Beginning of insurance contract and coverage

1. The insurance contract is concluded as soon as the insurer notifies the insured that it has accepted the proposal.
2. Coverage commences on the effective date indicated on the insurance policy.
3. The non-availability periods specified in the special terms and conditions of insurance are reserved.

Art. 11 Non-disclosure

1. If the policyholder, when responding to questions, concealed or stated incorrectly an important fact that he knew of or should have known (concealment), the insurer has the right to terminate the contract, within four weeks from the time of becoming aware of the concealment.
2. Termination shall take effect when it reaches the policyholder.

Art. 12 Term of insurance

1. The insurance term is one calendar year running from 1 January to 31 December.
2. If the contract is concluded during the course of a calendar year, the first insurance term runs from the effective date confirmed in the policy to the end of the calendar year.

Art. 13 Duration and termination of insurance contract

1. The contract is concluded without a time limitation, unless otherwise provided for in the special terms and conditions of insurance.
2. After three insurance terms, the policyholder may terminate the contract individually at the end of a calendar year by giving three months' notice. Exceptions to this are certain products, for which the term after which the policyholder may terminate the contract in accordance with the special terms and conditions is different. In accordance with Art. 35a para. 4 LCA/VVG, only the policyholder is allowed to exercise this right of termination.
3. The insurer may terminate the contract in case of fraud or attempted fraud.
4. After each claim for which a benefit is paid by the insurer, the policyholder has the right to withdraw from the insurance product concerned within 10 days of becoming aware of the payment of the benefit. In accordance with Art. 35a para. 4 LCA/VVG, only the policyholder is allowed to exercise this right of termination. 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. The insurer remains entitled to the payment of 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.
5. The right of termination for breach of the duty to inform by the insurer prior to the conclusion of the contract expires four weeks after the policyholder becomes aware of the breach and the information, but at the latest two years after the breach. The termination shall take effect when it reaches the insurer. The premium is due only until the end of the contract if the latter is terminated or ends before its expiry date.
6. The contract may be terminated at any time by the policyholder or the insurer for good reasons within the meaning of Art. 35b LCA/VVG.
7. The policyholder must give notice of termination in accordance with Art. 37 of these general terms and conditions of insurance.

Art. 14 End of insurance contract

The insurance contract and entitlements to benefits cease:

- a. at the death of the insured;
- b. on termination of the insurance contract;
- c. if the insurer rescinds the contract for non payment of premiums in accordance with Art. 21(1) LCA/VVG;
- d. in the event of a transfer of residence abroad, on the date of departure from Switzerland as notified to the competent municipal or cantonal authorities, provided that no other

- arrangements have been made within the meaning of Art. 4a of these terms and conditions of insurance;
- e. if the insured person residing abroad no longer fulfils the conditions for continued coverage as set out in Art. 4a of these terms and conditions of insurance.

Art. 15 Scope and duration of benefits

1. The benefits provided by the insurer for each insurance product are governed by the corresponding special terms and conditions of insurance.
2. Save any provision to the contrary in the special terms and conditions of insurance, accident benefits have the same scope as illness benefits.

Art. 16 Entitlement to benefits

1. Entitlement to benefits may only be claimed for illnesses or accidents occurring during the term of insurance.
2. The insured person must provide the insurer with detailed invoices.
3. At the insurer's request, the insured person must send the original invoice and other necessary supporting documents (medical reports, prescriptions, payment receipts, etc.).

Art. 17 Payment of benefits

1. As a rule, insured persons are liable for paying fees directly to healthcare providers. However, they shall agree to contracts concluded between the insurer and healthcare providers which, as an exception, provide for direct payment to healthcare providers.
2. Benefits are payable after the insurer has received all requisite information and documents enabling it to ascertain that the claims are well-founded and due.
3. The insurer can only settle accounts based on detailed invoices indicating the treatment dates, type of treatment, medical services provided, cost of each benefit and the names, addresses and telephone numbers of the Swiss and foreign healthcare providers. If necessary, the insurer may demand that documents in foreign languages be translated into one of Switzerland's official languages at the cost of the insured person.
4. Insured persons living abroad must communicate to the insurer a payment address in Switzerland.

Art. 18 Exclusions

1. Coverage is excluded:
 - a. for illnesses, accidents and their sequels which already existed when the contract was signed or which are subject to restrictions;
 - b. for illness, accident and their sequels after the insurance contract has expired, as well as when benefits were paid out during the insurance term. This does not affect the obligation to grant periodic benefits in accordance with Art. 35c LCA/VVG;
 - c. for dental treatment, insofar as coverage is not expressly provided for in the various insurance products;
 - d. for the costs of an inefficient, inappropriate or uneconomical treatment. Inefficient refers to treatments that

- have not been scientifically proven. Inappropriate refers to treatments that are contraindicated or cannot be tolerated, or when the medical indication has not been clearly established. Uneconomical refers to treatments that could have been replaced by another more affordable treatments; or to treatments that are unnecessary;
- e. for infertility treatments;
 - f. – for operations designed to correct or eliminate physical defects or cosmetic imperfections of an aesthetic nature, unless they are required following an insured event;
– for rejuvenation cures or interventions designed to improve physical performance;
 - g. for treatment resulting from suicide, voluntary self-mutilation or attempts of one or the other;
 - h. for health damages caused by ionising rays and health damages caused by nuclear radiation;
 - i. for the consequences of events of war:
 - in Switzerland;
 - abroad, unless the insured was surprised by this event in the country where he is staying and the illness or accident occurs within 15 days of the start of these events;
 - j. for the consequences of disturbances of any kind and measures implemented to counteract them, unless the insured person can prove that he did not actively participate on the side of the perpetrators or incite them to further violence;
 - k. for illnesses caused by alcohol addiction;
 - l. for illnesses and accidents due to the overuse of medication or alcohol or the use of narcotics (drugs);
 - m. for sex change operations, including treatments and consequences;
 - n. for organ transplants for which the “Fédération suisse pour tâches communes des assureurs-maladie” (SVK) has provided for lump-sum payments per case. This rule also applies to hospital facilities which are not bound by agreed lump-sum rates (flat rates per case).
2. Moreover, are excluded illnesses or accidents which the insured suffers:
 - a. during military service abroad;
 - b. during earthquakes;
 - c. while deliberately committing or attempting to commit a crime or punishable offence, or while participating in acts of war or terrorism;
 - d. in the event of traffic accidents in which the insured person has a blood alcohol level that constitutes a serious offence under the Road Traffic Act;
 - e. while taking part in brawls and fights, unless he was injured as an innocent bystander or while attempting to assist a helpless person;
 - f. through exposing himself to danger by seriously provoking a third party;
 - g. during hazardous activities, i.e. activities where he exposes himself to extreme danger without being able to reduce risks to a reasonable level.

Art. 19 Gross negligence on the part of the insured

If the loss was caused by gross negligence on the part of the insured, the insurer's liability shall be reduced proportionately.

Art. 20 Multiple coverage and third party benefits

1. The benefits governed by these general terms and conditions of insurance are supplemental to the benefits provided by foreign or Swiss social security and private insurers, and to compulsory health insurance benefits in particular.
2. In the case of multiple insurance under the LCA/VVG, each insurer is liable for the loss in the proportion that the amount insured by it is equal to the total amount insured.
3. Upon occurrence of an insured event, the insurer is subrogated, within the limits of the benefits provided by it, to the rights of the insured against any third party liable for the event. The insurer is not bound by any agreements between the insured person and any third parties liable for benefits.
4. In absence of compulsory health insurance coverage, within the meaning of LAMal/KVG, benefits under this contract will be payable as if compulsory coverage existed.

Art. 21 Multiple insurance

1. If the same interest is insured for the same risk and the same duration by more than one insurer, and the aggregate insured sum exceeds the insurance value (multiple insurance), the policyholder shall notify the insurer without delay.
2. If the policyholder is not aware of multiple insurance when concluding a subsequent contract, he may terminate this contract within four weeks of becoming aware of multiple insurance.
3. If the policyholder deliberately fails to do so, or if he contracted multiple insurance with the intent of making an illegal profit, the insurer shall not be bound by the contract vis à vis the policyholder. The insurer shall be entitled to the full premium.

Art. 22 Excess benefits

1. The insurance benefits provided within the framework of the products governed by these general terms and conditions must not lead to excess benefits for the policyholder.
2. In the event of excess benefits, these shall be reduced accordingly.
3. This provision does not apply to products that fall within the scope of fixed-sum insurance.

Art. 23 Healthcare providers recognised by the insurer

1. Treatments administered by healthcare providers recognised both by the compulsory health insurance (LAMal/KVG) and the insurance company are covered by the insurer.
2. Other healthcare providers not recognised under the compulsory health insurance (LAMal/KVG) may be recognised by the insurer.
3. **Before each treatment, the insured person must find out whether the healthcare provider who is to attend him is one of the healthcare providers recognised by the insurer.**
4. The insurer may keep a list of recognised or excluded healthcare providers.
5. The insurer may change the list of healthcare providers mentioned in paragraphs 1 and 2 above at any time.
6. Such modifications do not give policyholders the right to terminate their contract.

Art. 24 Tariffs of healthcare providers

1. The insurer recognises the tariffs applied by the Swiss social insurances and the private tariffs applied under tariff agreements to which it has adhered.
2. Entitlement to benefits is restricted to the tariff recognised by the insurer for the healthcare provider concerned.
3. The insurer is not bound by any rates' agreements concluded between issuers of invoices and insured persons.
4. In the event of dispute over medical rates, the insured person shall assign his rights to the insurer against the healthcare provider.

Art. 25 Assignment and pledging of benefits

Insured persons may not assign or pledge their claims against the insurer without the latter's consent.

Art. 26 Premium rates

1. Premiums are set based on a product-specific rate.
2. Rates may provide for differentiated premiums according to the gender, place of residence and age group of the insured person, as well as other criteria defined in the special terms and conditions of insurance.
3. The relevant age groups are in principle defined in the special terms and conditions of insurance.
4. A change in age group will in principle result in an automatic adjustment of the premium for the insured persons concerned.
5. The insurer may change the grading of the last age group if this is justified by demographic or actuarial reasons.
6. The insurer may change the premiums applicable to each region if justified by different cost trends within a premium region or between different premium regions.
7. In the event of a premium increase due to a change in age group, a change in the grading of the last age group, or a change in the premium regions, the policyholder is entitled to terminate the contract in accordance with Art. 29, para. 3 of these general terms and conditions.

Art. 26a Discounts and bonuses

1. The insurer may grant discounts or bonuses, the details of which are stated in the insurance policy and/or in the special terms and conditions of insurance.
2. The categories of discounts are as follows:
 - a. Discounts in connection with a framework agreement: these are defined in Art. 40 of these general terms and conditions.
 - b. Combination discounts: the special terms and conditions or contractual conditions define the combination of products that qualify for the discount.
Discounts may be modified in accordance with Art. 29 of these general terms and conditions.
 - c. Discounts resulting from a time-limited campaign: the entitlement to a discount is valid for a period defined contractually.
 - d. Reductions for families, children and young adults: the entitlement to a discount is valid as long as the insured person meets the criteria for entitlement.
The special terms and conditions define the criteria for granting the discount.
The insurer may change or withdraw discounts or bonuses at any time, with effect from the end of the current calendar year at the latest.
3. In the event of a reduction/withdrawal of discounts or bonuses, the policyholder shall have the right to terminate the contract in accordance with Art. 29 para. 3 of these general terms and conditions.
There is no right of termination if the contractual terms and conditions for granting the insurance are no longer fulfilled by the policyholder, nor for discounts or bonuses granted as part of time-limited promotional campaigns.

Art. 27 Payment of premiums

1. Premiums are payable yearly in advance in Switzerland; subject to special agreement and to a surcharge for costs, premiums may also be paid in six-monthly, quarterly or monthly instalments.
2. The premium billing period is at least one month, except for the month during which the insurance begins or ends.

Art. 27a Formal reminder, notice of default and debt recovery proceedings

1. If the premium is not paid by the due date, the debtor is summoned, at his own expense, to make payment within 14 days of the date of the notice, with a reminder of the consequences of late payment. If the formal notice has no effect, the insurer's duty to pay benefits will end after the reminder period has lapsed.
2. The insured cannot claim benefits for illness, accidents or their sequels which existed or appeared during a suspension of the obligation to provide benefits, even if the premium was subsequently paid.
3. If the insurer initiates collection proceedings against a policyholder, it may claim administrative expenses.

Art. 28 Reimbursement of annual deductibles and co-insurance payments

1. If the insurer pays the healthcare provider directly, the policyholder shall transfer the agreed annual deductible and/or his co-insurance payment to the insurer within 30 days of the insurer's invoice date.
2. If the policyholder does not honour his payment obligation, Art. 27a shall apply *mutatis mutandis*.

Art. 29 Adjustment of premium rates

1. Each year, the insurer may adjust the premium rate and premium discounts (in accordance with Art. 26a), in particular due to:
 - changes in the frequency or expense of claims;
 - the adjustment of the scope of coverage in accordance with Art. 36 of these general terms and conditions.
2. The insurer shall inform the policyholder of the new contractual terms at least 30 days before the expiry of the insurance term.
3. In the event of a premium increase (see paragraph 1 above), the policyholder shall be entitled to terminate the insurance contract affected by the increase, within 30 days of receiving the policy or being notified of the increase, with effect for the end of the ongoing insurance term. Notice of termination must have been received by the insurer within 30 days. If the policyholder does not terminate the contract, the adjustments made to the premiums shall be deemed to have been accepted.
4. In the event of a reduction in the premium rate (see para. 1 above), the policyholder has no right of termination.
5. A change in premium rates due to a change of address is not considered to be an adjustment of the premium within the meaning of the above provisions. The right of termination does not apply in this case

Art. 30 Set-off

1. The insurer may set off benefits payable against its receivables against the insured.
2. Insured persons have no right of set-off against the insurer.

Art. 31 Obligations in case of an insured loss

1. When applying for insurance benefits, the insured person must provide the insurer with all medical certificates, reports, documentation and invoices from the various healthcare providers within the timelimits specified in Art. 38 of these general terms and conditions.
2. If an insured person is admitted to a hospital or clinic, the insurer must be notified within five days of the admission date. If the insurer is required to guarantee coverage, it must be notified before admission.
3. The insured person or the beneficiary must report accidents to the insurer promptly, within 10 days of its occurrence at the latest. Information must be provided on the following:
 - a. the time, place, circumstances and sequels of the accident;

- b. the doctor or hospital;
 - c. any persons whose liability is involved and the insurances concerned.
4. The death of an insured must be notified to the insurer by the beneficiary within 30 days at the latest, even if the accident was already declared.
 5. In the event of a breach of obligations in the event of a claim, the insurer may reduce or refuse benefits. These penalties shall not apply if the breach of duty is not the fault of the insured person or if the insured person can prove that the breach of duty had no influence on the occurrence of the anticipated event and on the extent of the benefits payable by the insurer.

Art. 32 Obligation to notify

1. Any changes (name, first name, gender, marital status, place of residence, email address, telephone) as well as any deaths must be reported to the insurer as quickly as possible. In the event of a breach of his obligations, the insured person shall bear the consequences and the resulting costs.
2. When an insured person transfers his address and usual residence outside Switzerland, he must notify the insurer and provide a certificate of departure from his municipality or canton. On this basis, the insurer will terminate the insurance contract on the departure date indicated on the certificate.
3. If the insured person fails to notify the insurer of his departure, or fails to notify it within an appropriate period of time, the insurer may terminate the contract with retroactive effect to the actual date of departure. In this case, any undue benefits will be claimed from the insured person.
4. The insurer reserves the right to maintain contracts due to the continuation of compulsory health insurance in Switzerland in accordance with Art. 4a.

Art. 33 Information and verification

1. The insured person expressly authorises healthcare providers who provided treatment for the illness or accident, or on other occasions, to communicate all relevant information to the insurer's medical advisor for the purpose of appraising the case. To that effect, the insured shall release them from their professional secrecy obligation.
2. If the insurance coverage is supplemental to other private or social health insurance, the insured person must provide the insurer with the statement of benefits paid by the other insurers.
3. The insurer is entitled to request expert opinions, at its expense, from any doctors or specialists of its choice in order to establish the condition of the insured and his capacity for work. The insured person undertakes to submit to such examinations which are designed to establish the diagnosis and the entitlement to benefits.
4. The insured person must submit at any time to the supervision of the insurer's inspectors and medical advisors. He shall follow their instructions with a view to accelerating his recovery. Insured persons who refuse to undergo examination by the insurer's designated medical advisor risk having benefits refused.

Art. 34 Obligation to reduce damages

1. In the event of illness or accident, the insured person shall consult a qualified licensed healthcare provider from the outset and duly follow his instructions. He shall avoid impeding his own recovery or prolonging his sickness and shall comply with the practitioner's instructions for going out. The insurer is not liable for any worsening in the sequels of a illness or accident due to belated consultation of a healthcare provider or failure to comply with the healthcare provider's orders.
2. The insured person cannot induce a healthcare provider to carry out useless or uneconomical checks and treatment (e.g. unnecessary house calls, inpatient treatment instead of outpatient treatment, medical tourism, etc.).

Art. 35 Fraudulent invoices and insurance fraud

1. Benefits are not due for fake or forged invoices or in case of insurance fraud or attempted insurance fraud.
2. In such cases, the insured shall cover the cost of the insurer's verifications and handling of the case.

Art. 36 Adjustment of insurance terms and conditions

1. The insurer has right to adjust the terms and conditions of insurance, in particular in case of changes in any of the following areas:
 - a. progress of modern medicine;
 - b. establishment of new or onerous forms of therapies such as operating techniques, medication and the like;
 - c. increase in the number of health service providers, or establishment of new types of health service providers;
 - d. changes in compulsory health insurance benefits.
2. The new terms and conditions are valid for the policyholder and the insurer provided the adjustment is made in accordance with paragraph 1 during the term of insurance.
3. The insurer shall notify the policyholders of these adjustments. If the policyholder does not accept the changes, he may terminate the relevant 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 be accepted.

Art. 37 Notices

1. Notices between the policyholder and the insurer are valid if they are sent in writing or by any other means that can be proved by written text (email or another mean of communication made available by the insurer), with the exception of social networks.
2. Notices from the policyholder must be sent to the postal or email addresses indicated on the insurer's official documents.
3. Notices from the insurer are valid if they are sent to the last postal or email address communicated to the insurer by the policyholder or the insured person.
4. The insurer may also send general communications to the policyholders via the magazine for its insured persons. The

insured person who no longer wishes to receive the magazine may so request from the insurer, in which case the insurer is released from any liability 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. 38 Statute of limitations

Claims under the insurance contract become statutebarred within five years of the event giving rise to the obligation.

Art. 39 Special terms and conditions of insurance

1. For each of its insurance products, the insurer shall issue special terms and conditions supplementing the present general terms and conditions.
2. In case of discrepancy between the special terms and conditions of insurance and these general terms and conditions, the special terms and conditions shall prevail.

Art. 40 Framework agreement

1. For all insurance products, the insurer may conclude framework agreements with contractual partners (co-contractors) for the affiliation of persons with a specific legal relationship to this co-contractor.
2. The insurer may grant discounts in connection with a framework agreement.
3. The conditions for granting and withdrawing the discounts are communicated to the policyholder before the contract is concluded.
4. Discounts may be modified in accordance with Art. 29 of these general terms and conditions of insurance, depending on changes in the frequency or expense of claims.
5. An adjustment to the framework agreement may also result in the adjustment or cancellation of the discount, with effect from the end of the current insurance period.
6. Entitlement to discounts shall lapse if the insured person leaves the circle of persons entitled to insurance or if the framework agreement is terminated.
7. In the event of an adjustment or cancellation of the discount, the policyholder is entitled to terminate the insurance contract, with effect for the end of the ongoing insurance term, within 30 days of receiving the policy or being notified of the adjustment.

Art. 41 Place of performance and jurisdiction

1. Save special provisions to the contrary, the obligations arising from the contract shall be performed in Switzerland and in Swiss francs.
2. In case of dispute, the policyholder or the beneficiary may choose the jurisdiction of the courts of his place of residence in Switzerland, or of the registered office of the insurer subject to international treaties.

Art. 42 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: persons concerned) on behalf of Groupe Mutuel Assurances GMA SA, your insurer. Data processing is entrusted to Groupe Mutuel Services SA (hereafter: Groupe Mutuel), a company under Groupe Mutuel Holding SA. Both companies are subject to the Federal Law on Data Protection (LPD/DSG).

Personal data refers to information relating to the persons concerned, including the administrative management of the insurance contract. Sensitive data refers to information relating to the state of health of insured persons and claims. In general, the following categories of personal and sensitive data are processed: the declaratory personal data of the persons concerned, i.e. the data that Groupe Mutuel may collect from the persons concerned when they express interest and/or subscribe to products and services that the insurer offers or distributes; personal data relating to the benefits provided or the functioning of products and services or their use, in particular when using online services; personal data from third parties, other services or public information where 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 Federal Law on Data Protection); the contract concluded between Groupe Mutuel and the persons concerned.

Purposes

Personal data is 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 claims in respect of the rights of persons, 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, shared and exchanged between Groupe Mutuel and third parties (see below). These exchanges are the subject of contracts specifying the obligations and responsibilities of each of the parties, or are based on a legal provision.

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 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.

Profiling

During its relationship with Groupe Mutuel, the person concerned may be subject to marketing profiling, so that the insurer can offer services and products that meet the person's expectations, profile and needs. The modalities of this profiling are specified in the appropriate data protection policy. Other types of profiling may take place for the purposes outlined above.

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

Art. 43 Protection of data relating to personal advice and guidance

1. The insurer may collect and use, from the beginning of the insurance contract, the demographic, contractual and medical information of the insured person for the following purposes:
 - to issue recommendations on prevention and health promotion;
 - to provide advice on all health-related matters;
 - to recommend suitable healthcare providers to attend to the insured person's health problem;
 - to suggest targeted offers for products or services that meet the criteria of cost-effectiveness.
2. The data used to provide the services described in paragraph 1 may be taken from all records concerning the insured person compiled within any of the companies of Groupe Mutuel Holding SA (including compulsory health insurance).
3. In order for data from the compulsory health insurance records to be communicated for one of the above-mentioned purposes, the insurer will require the additional express consent of the insured person in each specific case.
4. The insured may withdraw his consent at any time in accordance with Art. 42 of these terms and conditions of insurance.