General Terms and Conditions for Supplemental Health and accident insurance of Groupe Mutuel Assurances GMA SA

CGC

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Contents

Groupe Mutuel Assurances GMA SA, hereafter referred to as GMA, is the Insurer in accordance with the present General Terms and Conditions of Insurance (CGC).

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

1. Unless otherwise stipulated in the insurance terms, 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, 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 corresponding special terms and conditions.

Art. 2 Purpose of insurance

The insurance mainly covers the economic consequences of illness, maternity and accidents. Specific special conditions enable the insured to waive coverage for one or more of the aforesaid risks.

Art. 3 Definitions

1. Illness means any impairment of the insured'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.

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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. Unless they were clearly caused by an illness or by degenerative phenomena, the bodily injuries enumerated in the following exhaustive list are equated with an accident even if they were not caused by an extraordinary external factor:
   a. fractures;
   b. dislocated joints;
   c. torn meniscus;
   d. torn muscles;
   e. strained muscles;
   f. torn tendons;
   g. torn ligaments;
   h. lesions of the eardrum.
3. Maternity includes pregnancy, childbirth and postnatal convalescence.

Art. 4 Territorial validity

1. The coverage is valid worldwide. In case of journeys and temporary stays outside Switzerland and the Principality of Liechtenstein, the insurance coverage is valid for a maximum of 12 months from the date of crossing the border unless special conditions are agreed: coverage will be suspended thereafter. In case of a prolonged stay abroad, the insured must notify the Insurer within 20 days.
2. Insured persons wishing to benefit from continued coverage abroad after the 12-month period referred to in paragraph 1 must apply in writing to the Insurer no later than 30 days before the end of the insurance year. The Insurer reserves the right to accept or refuse to extend the coverage abroad for a maximum period of 12 months.
3. If the insured fails to notify the Insurer of his stay within the aforesaid time limit, the Insurer reserves the right to reduce or refuse claims for benefits abroad.
4. If an insured falls ill in Switzerland or Liechtenstein and seeks medical treatment elsewhere, the cost of such treatment will only be reimbursed if the attending doctor submits an application to the Insurer in advance and the Insurer accepts it.

Art. 5 Policyholder and insured person

1. The policyholder is the person who concludes the insurance contract with the Insurer.
2. The insured person specified on the policy is the insured.

Art. 6 Insurance proposal

1. A signed insurance proposal is not a request for an offer but a formal declaration of intent by the applicant to the Insurer to subscribe to one or more supplemental insurance policies. The applicant is bound towards the Insurer in accordance with Article 1 LCA/VVG, namely for 14 days, or four weeks if medical inquiries have to be made.
2. As a rule, the insurance proposal is made in writing on the form supplied by the Insurer. The applicant must answer all the questions in the insurance proposal and the health questionnaire truthfully and completely. If the answers are written by a third party or an agent, he is responsible for ensuring that they correspond to his indications. Insured persons must authorise third parties to provide all requisite documents and information to the Insurer.
3. The Insurer reserves the right to accept or refuse the insurance proposal, to decide exclusions or to apply a surcharge. The Insurer is not obliged to substantiate such decisions.
4. The decision to refuse or restrict coverage in respect of one or more insurance products in the insurance proposal does not warrant a withdrawal from the other products which were proposed and accepted.
5. The decision to refuse or restrict coverage for family members of the insured (spouse, children) in respect of one or more insurance products in the insurance proposal does not warrant the insured's withdrawal from his own insurance proposal or contract(s).
6. For persons who do not have legal capacity, the insurance proposal must be signed by their legal representative.

Art. 7 Medical examination

1. The Insurer may demand to have a medical certificate issued at its expense.
2. It can also require the applicant to undergo 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 if experience shows that relapses are possible. The insured may accept or refuse the restriction. If the insured does not accept the restriction, the contract will not be concluded.
2. Restrictions are valid for the entire duration of the contract. An insured person may have a certificate issued at his cost certifying that a restriction is no longer justified. In that case, the Insurer is entitled to maintain or cancel the restriction.

Art. 9 Application for an increase in coverage

1. The proposal for increased coverage of an insured risk (e.g. decrease in deductible or higher insured amount) within the same product is regarded as a proposal for a new insurance contract within the meaning of Article 1 LCA/VVG.
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 Article 1 LCA/VVG and Article 6 of these General Terms and Conditions of Insurance. Contractual terms such as termination notice and waiting periods shall start to run anew and no acquired rights will be taken over from the earlier contract.

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. Notwithstanding, the qualifying and waiting periods specified in special rules are applicable.

Art. 11 Non-disclosure

If, when concluding an insurance contract, a policyholder fails to disclose, or inaccurately discloses, an important fact of which he was or should have been aware (non-disclosure), the Insurer is entitled to revoke the contract in writing within four weeks of becoming aware of the non-disclosure.

Art. 12 Term of insurance

The insurance term is one calendar year running from 1 January to 31 December.

Art. 12a Eligibility limits

The insured is eligible for coverage:

– without age limits unless otherwise provided in the special terms and conditions;
– in the case of reduced earnings coverage, up to the end of the month preceding the entitlement to an AVS/AHV pension;

Art. 13 Duration and termination of insurance contract

1. The contract is concluded for an indefinite duration unless otherwise provided in the special terms and conditions.
2. The policyholder may individually terminate the insurance after five years of coverage, and every year thereafter, subject to six months advance notice for the end of any calendar year. Excepted are certain products where other notice periods for termination by the policyholder are specified in the special terms and conditions.
3. The Insurer's right to terminate the contract in case of fraud or attempted fraud remains reserved.
4. In each case of damage or loss where a benefit is paid by the Insurer, the policyholder may withdraw from the relevant insurance product no later than 10 days after learning that the indemnity was paid. If the policyholder withdraws from the contract, coverage ceases 14 days after the Insurer receives the notice of termination; the Insurer shall be entitled to keep the premium for the current insurance term if the policyholder terminates the contract in the year after the coverage came into effect. In all other cases, the premium is only due until the end of the contract.
5. The Insurer expressly waives his legal right to cancel the contract following loss or damage save in case of misrepresentation, fraud or non-disclosure, or attempted misrepresentation, fraud or non-disclosure.
6. The right to terminate on the ground that the Insurer breached its obligation to inform when the contract was concluded expires four weeks after the policyholder becomes aware of the infringement and of the information, but no later than one year after the infringement. The termination takes effect when it is received by the Insurer. The premium is only due until the end of the contract if the contract is terminated or ends before it is due.
7. The policyholder must send the notice of termination by registered mail with an original signature. Notices of termination sent by fax or email (with or without a scanned termination letter in annex) are not accepted.

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 Article 21(1) LCA/VVG;
d. if the insured transfers his residence abroad, on the departure date declared to the competent municipal or cantonal authorities unless otherwise agreed in writing (Article 32(2)).

Art. 15 Scope and duration of benefits

1. The scope and duration of coverage and the benefits provided by the Insurer under each insurance product are subject to the relevant 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. Payment of benefits is conditional to presentation of a medical certificate and detailed original invoices.
3. The special terms and conditions for supplemental insurance are applicable.

Art. 17 Payment of benefits

1. As a rule, insureds are liable for the fees of health care providers. They accept, however, derogating agreements concluded between the Insurer and health care providers providing for direct payment by the Insurer to the health care provider.
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 original, detailed invoices indicating the treatment dates, diagnosis, medical services provided, cost of each service and the names, addresses and telephone numbers of the Swiss and foreign health care 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.
4. Insured persons living abroad must communicate a payment address in Switzerland to the Insurer.

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 illnesses, accidents and their sequels which came into being after the end of the insurance contract even if benefits were paid during the insurance term;
   c. for cosmetic surgery operations designed to correct or eliminate physical defects or imperfections, unless such operations are required as a result of an insured event; rejuvenating cures, tissue or cell implant treatments;
   d. in case of suicide and self-inflicted injuries or attempts at either;
   e. for dental treatment, unless coverage is specifically foreseen in the relevant insurance product;
   f. for damages to health caused by ionising rays or by atomic energy;
   g. for the cost of ineffectual, inadequate or uneconomical treatment. Ineffectual treatment means treatment whose effectiveness is not scientifically demonstrated. Inadequate treatment means treatment that is contraindicated or unsuitable, or not based on clear medical indications. Uneconomical treatment is treatment which could have been replaced by less expensive treatment, or treatment that is useless;
   h. for the consequences of events of war:
      – in Switzerland and in the Principality of Liechtenstein;
      – abroad, unless such events catch the insured by surprise in the country where he is staying and provided the illness or accident occurs no more than 15 days after the beginning of the events;
   i. for the consequences of any kind of unrest, and of the measures to combat it, unless the insured can prove that he did not actively participate in the unrest alongside the troublemakers and that he did not foment it;
   j. for illnesses due to alcoholism and other addictions;
   k. for illnesses and accidents due to drug abuse and addiction;
   l. for sex changes including treatment and sequels.
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. while taking part in brawls and fights, unless he was injured as an innocent bystander or while attempting to assist a helpless person;
   e. through exposing himself to danger by seriously provoking a third party;
   f. 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. In case of double private insurance, the benefits under these General Terms and Conditions of Insurance are granted subsidiarily to those granted by the other insurer unless the terms and conditions of such other insurer also contain a subsidiarity clause in which case the double insurance rules shall apply.
2. 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.
3. In absence of compulsory health insurance coverage, within the meaning of LAMal/KVG (the Federal Health Insurance Law), benefits under the present contract will be payable as if compulsory coverage existed.

Art. 21 Double 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 (double insurance), the policyholder shall notify the Insurer promptly in writing.
2. If the policyholder deliberately fails to do so, or if he contracted double 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 Overinsurance

Where the insured sum exceeds the insurance value (excess insurance), the Insurer shall not be bound by the contract vis à vis the policyholder if the latter concluded the contract with the intent of making an illegal profit through overinsurance. The Insurer is entitled to the full premium.

Art. 23 Providers of health care services

1. The Insurer only covers services provided by recognised health care providers, namely the persons and facilities defined in the health insurance legislation.
2. The other recognised providers are listed in the special terms and conditions for each product.

Art. 24 Tariffs of health care 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 health care provider concerned.
3. The Insurer is not bound by any fee agreements concluded between issuers of invoices and insured persons.

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 generally differentiated by gender, region and age group.
2. As a rule, the method used for setting premium rates is specified in the relevant special terms and conditions.

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. Premiums are due for an indivisible month.

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

1. If the premium is not paid when due, a reminder shall be sent to the debtor, at his cost, requesting payment within 14 days and pointing out the consequences of late payment. If the reminder has no effect, the Insurer's obligation to provide benefits ceases upon expiry of the notified time limit.
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 health care 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, Article 27a shall apply mutatis mutandis.

Art. 29 Adjustment of premium rates, deductibles and co-insurance

1. The Insurer may adjust premium, deductibles and co-insurance rates to allow for trends in costs, claims and changes in law.
2. The Insurer shall inform the policyholder of the new contractual terms at least 30 days before the expiry of the insurance term. In that case, the policyholder shall be entitled to terminate the corresponding insurance contract for the end of the current insurance term within 30 days of his receipt of the policy or the notice of increase. The notice of termination must be received by the Insurer within 30 days.
3. If the policyholder does not terminate the contract, the adjustments in premium, deductibles and copayment rates shall be deemed accepted.
4. A tariff change in the event of a move or the loss of an entitlement to a discount (including promotional discounts limited in time) does not qualify as an adjustment in premium for the purposes of the foregoing clauses. The right to termination does not apply in such cases.

Art. 30 Set-off

1. The Insurer may set off benefits payable against its receivables against the insured.
2. The insureds have no right of set-off against the Insurer.

Art. 31 Obligations in case of an insured loss

1. An insured person claiming benefits shall remit to the Insurer all requisite medical certificates, records, documents and invoices from all the health care providers concerned. Only original invoices will be accepted.
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. The Insurer reserves the right to reduce or refuse benefits in case of late notification.
3. The insured person must notify accidents to the Insurer promptly, within 10 days at the latest. He must provide due information on:
   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.

   The insurer reserves the right to reduce or refuse benefits if such information is notified belatedly.
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. If the Insurer is notified after this time limit, its obligation, if any, to pay benefits disappears.

Art. 32 Obligation to notify

1. Unless otherwise provided, changes of address or civil status and deaths must be notified to the Insurer within 30 days. If the insured fails to declare a change within the set time limit, the Insurer may claim from him any damages suffered as a result.
2. If an insured person transfers his domicile or residence outside Switzerland or the Principality of Liechtenstein, he must notify the Insurer within 30 days and provide a certificate of departure issued by his municipality or canton. If the insured fails to notify the Insurer, the latter shall be entitled to terminate the insurance coverage as soon as it becomes aware of the departure; termination shall be effective at the end of the month in which the insured's departure from Switzerland was declared to the competent cantonal or municipal authorities.

Art. 33 Information and verification

1. The insured person expressly authorises practitioners 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 practitioner 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 doctor or failure to comply with doctor's orders.
2. The insured person cannot induce a practitioner 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 Fake 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 shall be entitled to adapt the terms and conditions of each insurance product especially when there are significant changes in any of the following fields:
   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 the list of benefits covered under LAMal/KVG.
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. The Insurer shall communicate such adjustments to policyholders in writing. Policyholders who are not willing to accept such adjustments may terminate the corresponding contract with effect from the adjustment date. The new provisions shall be deemed accepted unless notice of termination is sent to the Insurer within 25 days.

Art. 37 Notices

1. Notices shall be addressed to the administrative office of Groupe Mutuel Assurances GMA SA.
2. Notices made by the Insurer are valid if they are sent to the last Swiss address communicated to the Insurer by the policyholder or the insured.
3. The Insurer may also publish general notices to insureds in its dedicated magazine.

Art. 38 Statute of limitations

Claims under the insurance contract become statutebarred within two 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 Collective insurance

In the context of collective contracts and for all its insurance products, the Insurer may derogate from the provisions of these General Terms and Conditions of Insurance in respect of:

– the identity of the policyholder;
– premium rates;
– beginning, duration and end of insurance coverage.

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.