

Collective Daily Allowance Insurance in case of illness under LAMAL/KVG

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Practical and legal information

The following information for clients provides a clear and concise overview of the identity of the insurer and the most important points contained in the insurance contract.

Who is the insurer?

The insurer is defined in the insurance contract.

What risks are insured and what is the scope of the insurance cover?

The insurance covers the economic consequences of incapacity for work (hereafter: «incapacity») due to illness, which means any impairment of a person's physical, psychological or mental health that was not caused by an accident and that requires a medical examination or treatment or gives rise to incapacity.

The insurance also covers the economic consequences related to maternity. Maternity includes pregnancy and delivery, as well as recovery from the latter.

Depending on the provisions in the contract, insurance coverage may also cover the risk of accident. Accident means any damaging, sudden and involuntary injury to the human body which is prejudicial to physical, mental or psychological health or leads to death and was occasioned by an extraordinary external cause.

Should the insured person die from the cause of the incapacity for work entitling him to benefits, the insurer shall pay the employer a daily allowance within the limits of the insurance coverage and the provisions of Article 338 of the Swiss Code of Obligations.

If it is included in the contract, extended loss of earnings coverage insures the income obtained through the remaining work capacity which is useful to the company, substantially and permanently, where the entitlement to benefits has been exhausted within the meaning of Article 6, para. 3 of the general terms and conditions of insurance. Extended coverage is granted for an additional duration of 180 days within a period of five years starting from the date of exhaustion of the benefits.

Insurance coverage is related to the incapacity, i.e. any full or partial loss by the insured of the capacity to perform work which could reasonably be expected of him within the limits of his profession or area of activity, provided such incapacity is

the result of a physical, mental or psychological impairment. In case of long-term incapacity, the work which could reasonably be expected of the insured person may also take place in another occupation or area of activity.

The insurance contract 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 possible special conditions.

Duration of payment of benefits:

The daily allowance is payable for one or several cases of incapacity during 730 days in a period of 900 days.

The waiting period payable by the employer will be deducted from the duration of entitlement to benefits.

All cases of incapacity that have given entitlement to collective benefits are covered by the collective contract.

The scope of insurance is set out in the general terms and conditions of insurance.

How is the premium calculated?

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

What are the obligations of the policyholder (employer)?

The obligations of the policyholder are defined in the general terms and conditions of insurance.

The policyholder shall inform the insured persons in writing

of their rights and obligations under the insurance contract, indicating in particular that they have the possibility of maintaining their insurance coverage if they leave the circle of insured persons or on expiry of the policy. For this purpose, he will receive documents from the insurer.

The policyholder shall also inform insured persons on the main points of the contract.

Furthermore, the policyholder must fulfil the following obligations:

- notify the insurer of cases of incapacity within 15 days of their occurrence;
- notify the insurer immediately of the termination of the employment relationship of an employee who has an incapacity;
- provide the insurer with the salary declaration form for the final invoicing and, if requested, the insureds' AVS/AHV statements within 30 days;
- afford the insurer, or the insurer's agents, access to the company's books and accounting information and to the documentation sent to the AVS/AHV Compensation Fund;
- provide any document capable of establishing the entitlement to benefits;
- notify the insurer of any event liable to aggravate risks (e.g. change in corporate business activities or in the insured's profession).

What are the obligations of the insured person?

The insured person must fulfil the following obligations:

- consult a licensed doctor at his practice at the latest three days following the beginning of the incapacity;
- release his attending practitioners from medical and professional secrecy vis à vis the insurer's medical advisor;
- cooperate with the insurer and with third parties mandated by the insurer (claims' inspector, officers, doctors, etc.), as well as with other social insurance institutions;
- make all efforts to limit damages;
- submit an application for benefits to the AI/IV disability office for no later than six months from the beginning of the incapacity or, upon request of the insurer, with another social institution;
- remain available for any necessary administrative or medical investigations of the insurer (such as be examined by a doctor designated by the insurer) during the incapacity;
- inform the insurer prior to departure outside the vicinity of the home (radius of 200 km), in accordance with Article 16, para. 1b of the general terms and conditions of insurance;
- 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 his case.

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

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

Benefits will be refused:

- in case of fraud or insurance fraud attempts;
- in case of incapacity during military service abroad.

Benefits may be reduced or refused temporarily or definitively:

- if the accident is caused by the fault of the insured, in case of extraordinary dangers and hazardous activities within the meaning of the LAA/UVG;
- if the policyholder or the insured do not respect their obligations under Article 23 and 24 of the general terms and conditions;
- if the insured refuses to comply with the insurers' instructions (e.g. be examined by the medical expert designated by the insurer) or fails to appear for a medical examination requested by the insurer without a good reason. In this case, the insurer also reserves the right to demand that any benefits already paid out be refunded and to bill the insured for the missed medical appointment;
- if the insured refuses to provide all information on the facts which could serve, to his knowledge, to determine the entitlement to benefits;
- if the insured fails to submit, or does not do so in good time, an application for benefits to the AI/IV disability office. In this case, daily allowance benefits will be suspended until the date of the application for benefits;
- if the person to be insured is not hired in good faith (including to avoid a risk assessment, or recover a new entitlement to benefits) or when the job offered is clearly incompatible with the insured person's physical and mental capacities or material resources (driving licence, etc.)

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

When does the contract begin?

The contract indicates the effective date as well as the expiry date which is on 31 December of a calendar year.

When does the insurance contract end?

- if the company ceases its business activities or if the company goes into bankruptcy;
- if premiums are not paid in accordance with Article 19, para. 7 of the general terms and conditions of insurance;
- when the headquarters or the place of residence of the policyholder is transferred abroad;
- in case of termination by the policyholder or by the insurer;
- in case of termination following an adjustment of the premium rates pursuant to Article 20 of the general terms and conditions of insurance.

These lists only contain the most common possible reasons for termination. Other possible reasons are mentioned in the general terms and conditions of insurance.

When does the insurance coverage begin?

For each insured person, coverage starts on the day of entry into force of the employment contract, but not before the contract comes into effect.

When do the insurance coverage and entitlement to benefits end?

For each insured person, insurance and entitlement to benefits ceases:

- at the end of the employment contract. However, coverage is maintained if the incapacity is ongoing at that time;
- at the end of the insurance contract;

- upon exhaustion of benefits as provided for in Article 6, para. 3;
- when the member reaches the regulatory retirement age or takes advance retirement;

If a member remains employed after the regulatory retirement date and failing an ongoing incapacity at that time, the employee will still be entitled to 180 daily allowance benefits at the latest until the end of the month during which he reaches 70 years old.

- at the end of the LAA/UVG accident coverage for the worker posted abroad.

How is the data processed by the insurer?

The insurer processes the personal data of the policyholder and the insured person.

Personal data means data relating to the insured person, the policyholder, the administrative management of the contract, the state of health of the insured person and claims.

Data is used in particular to assess the risks to be insured, handle claims, ensure administrative, statistical and financial follow-up of the contract. For this purpose, data may be exchanged between the policyholder, the insurer, Groupe Mutuel and third parties (e.g. reinsurer, AI/IV disability office, social insurance institutions of the insured person's country of residence).

Upon processing sensitive data, Groupe Mutuel, its insurers and member or managed companies, its agents and other authorised representatives (such as reinsurer), undertake to take all necessary measures to comply with legal provisions related to data protection.

Data is processed in a confidential manner and shall not be communicated to third parties (e.g. reinsurer, doctors, beneficiaries, AI/IV disability office, social insurance institutions of the insured person's country of residence) only upon legal foundations, legal decisions, general terms and conditions of insurance or with the consent of the concerned person. If data handling is subcontracted, outsourced or done in cooperation with third parties (e.g. reinsurer), the latter are made aware of data protection requirements and subject to the obligation to maintain secrecy. Data provided to agents of Groupe Mutuel will be recorded and sent to Groupe Mutuel for processing insurance applications and for the administrative and financial follow-up between the agent and the insurer.

Groupe Mutuel agents are made aware of confidentiality and data protection aspects and undertake by contract to comply with them. Personal data is held for as long as required by the management of the insurance contract, claims, recourse rights, debt recovery and/or any disputes between the insurer, the insured, the intermediary or third parties.

The policyholder and the insured person have the right to access their personal data, to have the data corrected, to have their data deleted within the limits of the applicable legal provisions, to limit the processing of their data, to request data transferability, to withdraw their consent to the processing of personal data subject to the processing required for the performance of the contract, to appeal to the competent supervisory authority.

Further information on data protection can be found at www.groupemutuel.ch.