

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

Edition: 01 Jan 2018

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.

General Terms and Condition for Collective Daily Allowance Insurance under LAMal/KVG

BE

BEGM03-E2 – Edition: 01 Jan 2018

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The Federal Law on General Social Insurance Law (LPGA/ATSG) and the Federal Law on Health Insurance (LAMal/KVG), as well as the relevant ordinances, supplement the provisions not contained in these general terms and conditions of insurance

A. General principles

Art. 1 Purpose of the insurance

The risk-bearing insurer is indicated on the policy. It guarantees to insure the economic consequences of an incapacity for work (hereafter: «incapacity») resulting from illness, maternity and accidents provided this risk is covered in the insurance contract.

Art. 2 Legal bases

The contract is based on:

- Swiss law and the agreements signed between Switzerland and third-party organisations and States, including:
 - the Federal Law on General Social Insurance Law (LPGA/ATSG);
 - the Federal Law on Health Insurance (LAMal/KVG);

- the Federal Law on Data Protection (LPD/DSG).

- These General Terms and Conditions of Insurance, as well as the provisions of the policy and the addendums thereto.
- The statements made in the insurance proposal and any other written statements of the policyholder and the insureds, as well as the relevant health questionnaires.

Art. 3 Definitions

- 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
LAA/UVG: Federal Law on Accident Insurance
LAM/MVG: Federal Law on Military Insurance
CO: Swiss Code of Obligations

EU: European Union

EFTA: European Free Trade Association

2. Relapse

An incapacity resulting from a condition having given rise to benefits within a prior incapacity will be equated with a relapse. It can no longer be equated with a relapse if it occurs more than 365 days from the end of the incapacity having given right to the above benefits.

3. Posted worker

The insured person working abroad for a Swiss employer and subject to LAA/UVG, as well as the insured person who is abroad for training purposes while simultaneously being paid by his Swiss employer.

4. Cross-border worker

A cross-border worker is a person carrying out a gainful activity in a country other than the one in which he resides within the European Union/EFTA and who returns home at least once a week.

B. Scope of insurance

Art. 4 Insurance contract

The insurance contract sets out the details of the insurance coverage, including the insured risks, the maximum salary amount 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. 5 Insured persons

1. The group of insured persons is specified in the contract.
2. Unless explicitly specified in the contract, persons who are fully or partially unable to work when the contract comes into effect, or at the start of their employment, are not insured. They will be covered as soon as they have recovered their full ability to work. The agreement regulating free transfer of coverage remains reserved.
3. A person who receives a disability pension at the beginning of the contract, or at the beginning of the employment relationship, is insured for the income obtained through the remaining work capacity from which he takes advantage substantially and permanently.

Art. 6 Insurance coverage

1. All cases of incapacity having entitled to collective benefits shall be charged to the collective contract.
2. Occupational illnesses and physical injuries equated with accidents under the LAA/UVG, and their sequels, are only covered by the accident insurance.
3. Daily allowance benefits are paid for 730 calendar days in a period of 900 days for one or more cases of incapacity.
4. If an insured was paid daily allowances by the former insurer, the corresponding number of days will also be deducted from the term of entitlement to benefits.
5. Employer's waiting periods will be deducted from the term of entitlement to benefits.

Art. 7 Affiliation with risk assessment

1. A medical examination may be required if stipulated in the proposal or policy.
2. Depending on the health of the person to be insured, the Insurer may grant restricted coverage (exclusions).
3. When the collective policy comes into effect, any exclusions decided by the former insurer shall be maintained in effect until the original term expires.

C. Start and end of insurance contract

Art. 8 Start and end of insurance contract

1. Effective date
The policy indicates the effective date as well as the expiry date, which is on 31 December of a calendar year.
2. Automatic renewal
At the expiry date, and unless the Insurer receives a notice of termination policy by 30 September of the current year, the contract shall be automatically extended from one year to the next.
3. End of contract
The contract will end:
 - a. if the company ceases its business activities or if the company closes down or goes into bankruptcy;
 - b. if premiums are not paid in accordance with Article 19, para. 7 of these General Terms and Conditions;
 - c. when the headquarters or place of residence of the policyholder is transferred abroad;
 - d. in case of termination by the policyholder or the Insurer;
 - e. in case of termination following a premium rate adjustment, within the meaning of Article 20 of these General Terms and Conditions.

Art. 9 Fraudulent claim

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

D. Insurance coverage

Art. 10 Start and end of insurance coverage and of entitlement to benefits

1. Start of insurance coverage
For each insured, coverage starts on the day of entry into force of the employment contract, but not before the policy comes into effect.
2. End of insurance coverage and of entitlement to benefits
Insurance coverage and the entitlement to benefits cease, for each insured:
 - a. at the end of the employment contract or collective contract. However, the coverage and entitlement to

benefits are maintained for the ongoing incapacity at the end of the contract, if the collective contract is effective at that date;

- b. when the entitlement to benefits provided for in Article 6, para. 3, is exhausted;
- c. at the end of the month during which the insured reaches standard retirement age, or when the insured goes into early retirement;
- d. at the end of the LAA/UVG accident coverage for the worker posted abroad.

Art. 11 Transfer to individual insurance

1. From the moment the insured is informed of his right to free transfer, he has 90 days to exercise his right by asking for an individual insurance offer.
2. A cross-border worker who no longer belongs to the group of insureds has the right to be transferred to individual coverage, without a new medical exclusion being pronounced, if he remains employed in Switzerland.
3. Referring to Article 10, para 2a, the right to free transfer to individual insurance is possible at the earliest at the end of the collective coverage for the ongoing incapacity.
4. The daily allowance shall be reduced proportionally if the amount of the new income or unemployment benefits is lower.
5. The prevailing tariffs and general terms and conditions for individual insurance will apply.
6. There is no entitlement to transfer to individual coverage:
 - a. in case of termination of the collective insurance contract and transfer of the contract to another insurer for the same group of insureds or part of the latter;
 - b. if the person to be insured was not hired in good faith;
 - c. if the insured person leaves his employment and is insured for daily allowance with a new employer;
 - d. subject to the applicable free transfer agreement.

E. Insured benefits

Art. 12 Insured benefits

1. Partial incapacity
The daily allowance shall be proportionate to the degree of incapacity (at least 25%). Days with a lower degree of incapacity are not taken into account for calculating the duration of benefits and waiting period.
2. Notification of incapacity
 - a. Each full or partial incapacity must be notified to the Insurer within 15 days following its occurrence. After this time limit, the day on which the Insurer is notified of the incapacity shall be deemed the first day of incapacity;
 - b. If the incapacity was notified late for excusable reasons, the payment of daily allowance benefits shall be limited to 180 days immediately preceding the day of the notification.
3. Medical certificate of incapacity
 - a. If the original certificate was issued more than three days after the start of the incapacity, the Insurer reserves the right to consider the date of issuance of the

certificate as the first day of the incapacity.

- b. The Insurer shall pay compensation for a medically attested and proven incapacity. For cases of incapacity lasting longer 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.
4. Exhaustion of benefits
The insured must not seek to avoid exhausting his entitlement to daily allowance benefits by waiving his right to a daily allowance. In this case, the Insurer shall pay benefits at the discretion of the medical advisor.
5. Calculation of daily allowance

- a. The insured daily allowance is calculated based on the AVS/AHV salary due by the insured company. The salary and part of the salary not subject to AVS/AHV because of the age of the insured person, as well as any family allowances from the time they are no longer received by a beneficiary, are also taken into account.
- b. For salary elements subject to AVS/AHV that were not yet paid at the time of the insured event and to which the person may be entitled, the corresponding daily allowance benefit is set by dividing by 365 the salary elements received during the 12 months preceding the incapacity, but no earlier than the date of hiring.
- c. If the allowance is expressed as a percentage of the insured's hourly wage or monthly salary, as the case may be, it shall be calculated as follows, up to the maximum ceiling fixed in the regulations relating to the collective agreement:

For hourly wages:

gross base hourly wage (plus 13th month if applicable)
times
average number of hours worked per week or per year
times
52 weeks (for hours on a weekly basis)
divided by
365 days (including leap year)
times
contractual coverage rate.

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

Monthly salary:

Monthly salary
times
12 months (or 13 months, if a 13th salary is paid)
divided by
365 days (including leap year)
times
contractual coverage rate.

- d. If the insured carries out gainful employment on an irregular basis or if the insured's income is subject to significant variation, the daily allowance is set by dividing by 365 the salary earned in the 12 months immediately preceding the incapacity.
- e. Salary components intended to compensate expenses relating to carrying out the professional activi-

ty (e.g. allowance for meals, representation expenses, etc.) are not taken into account in calculating the daily allowance.

- f. A salary increase during an incapacity can be taken into account if it was agreed upon before the incapacity or if it is provided for by a collective work agreement.
6. Waiting period
- a. The insured daily allowance is payable on expiry of the agreed waiting period, for each day of incapacity (Sundays and public holidays included). In calculating the waiting period, each day of partial incapacity giving entitlement to benefits counts as a full day.
 - b. If the waiting period per incapacity is provided for in the contract, it applies to each case of incapacity entitling to benefits. In case of a relapse, only the possible residual waiting period will be applied.
 - c. If the contract 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 annual waiting period will only apply once.
 - d. If the contract provides for a waiting period per year of employment, 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 of employment, the waiting period will only apply 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.

Art. 13 Benefits insured in the event of maternity

1. The insured daily allowance benefits are paid if, at childbirth, the insured had insurance coverage for at least 270 days without any interruption of more than three months and provided the pregnancy lasted at least 23 weeks or that the infant is viable.
2. Daily allowance benefits for maternity correspond to the amount of salary covered less any federal benefits or benefits from a cantonal maternity insurance coverage.
3. Daily allowance benefits for incapacity cannot be cumulated with those payable in connection with maternity.

Art. 14 Extended coverage

1. If a member remains employed after the ordinary retirement date and failing an ongoing incapacity at that time, the employee shall still be entitled to 180 daily allowance benefits at the latest until the end of the month of his 70th birthday.
2. Should the insured person die due to the incapacity 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.

3. Extended loss of earnings coverage
 - a. If it is included in the policy, extended loss of earnings coverage insures the income obtained through the insured's 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. 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.
 - b. The waiting period applies to each case of incapacity but is not deducted from the 180-day term.
 - c. An employee cannot be entitled to extended loss of earnings coverage if he has already exhausted his entitlement to daily allowance benefits more than once.
 - d. If, at the end of the five-year period running from the start of extended loss of earnings coverage, the insured has not exhausted his entitlement to extended coverage, he will once again be entitled to the main coverage stipulated in the policy, within the meaning of Article 6, para. 3.
 - e. Extended loss of earnings coverage will be strictly linked to the collective contract of the company with a view to fostering professional rehabilitation. The employee who no longer belongs to the group of insureds will not be entitled to free transfer for this benefit.

Art. 15 Unpaid leave of absence

1. During unpaid leave of absence, coverage can be maintained for a maximum of 12 months. To this end, before the departure of the insured person, the employer shall notify the insurer in writing of the duration of the unpaid leave of absence agreed contractually, if it exceeds one month. The entitlement to a daily allowance will first resume on the day the employee is scheduled to return to work. The waiting period shall run from the first day of incapacity.
2. Failing prior notification to the insurer of unpaid leave of absence, any incapacity that occurs during the absence will not give right to any benefits.

Art. 16 Benefits during a stay abroad or outside the vicinity of the home

1. Pursuant to Article 24, para. 1:
 - a. In the event of incapacity outside the vicinity of the home of the insured (radius of 200 km), the insured person is entitled to benefits as long as he can prove that a return to Switzerland would be inappropriate, in particular during the period of hospitalisation.
 - b. During his incapacity, the insured person who wishes to leave the vicinity of his home (radius of 200 km) must inform the Insurer prior to departure. In this case, the Insurer reserves the right to continue granting daily allowance benefits during a limited period, after having assessed the situation. In the absence of an agreement with the Insurer, benefits will be refused during the stay outside the vicinity of his home.

2. The employee posted abroad will be entitled to the same benefits for as long as he remains covered under the LAA/UVG accident insurance, but no longer than six years and, afterwards, upon his return to Switzerland.

Art. 17 Limitation of entitlement to benefits

1. Benefits are refused altogether:
 - a. in case of fraud or insurance fraud attempts;
 - b. in case of incapacity during military service abroad.
2. Benefits may be reduced or refused altogether temporarily or definitively:
 - a. 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;
 - b. if the policyholder or the insured does not respect its obligations under Articles 23 and 24 of these General Terms and Conditions;
 - c. if the insured refuses to comply with the 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 person for the missed medical appointment;
 - d. if the insured refuses to provide all information on the facts which could serve, to his knowledge, to determine the entitlement to benefits;
 - e. if the insured fails to submit, or does not do so in good time, an application for AI/IV disability benefits. In this case, the daily allowance benefits will be suspended until the date of the application for disability benefits;
 - f. if the person to be insured was not employed in good faith (in particular to avoid a risk assessment or to secure reentitlement to benefits) or when the proposed work is clearly incompatible with physical or mental capabilities, professional knowledge or material resources (driving license, etc.) of the insured person.

F. Premiums

Art. 18 Premium calculation

The premium is calculated based on the AVS/AHV salary due by the insured company. The salary and part of salary not subject to AVS/AHV because of the age of the insured person, as well as any family allowances, are also taken into account.

Art. 19 Premium payments

1. The policyholder is liable as debtor for the premiums.
2. Unless specifically agreed in the policy, the premium rate is fixed for each calendar year.
3. The premium is payable within the time limit specified in the policy.
4. The provisional premium may be adjusted at any time by the Insurer.
5. Premium instalments maturing in the course of a calendar year shall be considered as amounts payable for the relevant time limits. They may be adjusted at any time to allow for payroll changes in the course of the year.

6. If the premium or premium instalments are not paid in due course, a formal notice shall be sent to the debtor, at his cost, requesting payment within 14 days of the notice and pointing out the consequences of late payment. If premium arrears plus costs are not paid within the additional time limit, coverage and the entitlement to benefits shall be suspended. Once all arrears have been fully paid, the entitlement to benefits is reinstated retroactively from the date of suspension. In that case, the premium is due for the entire duration of the suspension.
7. If premium payments are more than two months late, the Insurer shall be entitled to terminate the policy, for the end of the month subject to one month's notice.

Art. 20 Adjustment of premium rates

1. Unless explicitly agreed in the policy, the Insurer may adjust the premium rate each year to allow for trends in claims or in the event of a change in premium rates. Premium rates shall be adjusted as of 1 January of each calendar year.
2. Premium rates may be adjusted in the event of a change in circumstances (e.g. in the case of a merger, spin off or take over) or if there is an important change in the composition of the insured group, provided that variations in payroll are at least 10 %.
3. The Insurer shall inform the policyholder of the new premium rate no later than 25 days before the expiry of the current year.
4. Changes are considered approved if the Insurer does not receive a termination notice by registered mail before the end of the year.
5. The Insurer shall be entitled to retroactively alter the premium rate to allow for the actual loss rate if cases of incapacity are announced at a later time. Retroactive adjustments shall be deemed approved if the Insurer does not receive a notice of termination by registered mail within 30 days of the notification of the change in premium. Termination shall be effective at the earliest at the end of the month in which the Insurer receives the termination notice.

Art. 21 Premium statements

The final premium statement will be prepared at the end of the calendar year based on the documentation provided by the policyholder pursuant to Article 23 of these General Terms and Conditions.

Art. 22 Surplus sharing

1. The agreed share of any surplus resulting from the contract shall be paid to the policyholder, in accordance with the terms and conditions of the contract.
2. The accounting is done at the earliest five months after the end of the accounting period but not before all losses during the period have been settled and indemnified.
3. If losses for a closed accounting period are declared or indemnified after the accounting statement has been drawn up, a new surplus-sharing statement will be prepared. The Insurer shall claim restitution of any excess surplus payments made.

4. Surplus-sharing payments are made subject to the condition that the insurance contract remains in force until the end of the accounting period.
5. When surplus-sharing is calculated, claims for cases arising during the term of collective coverage will be charged to the collective policy.

G. Other provisions

Art. 23 Obligations of the policyholder

1. The policyholder shall inform the insureds in writing of their rights and obligations under the insurance, indicating in particular that it is possible to maintain insurance coverage if they leave the insured group or after the policy expires.
2. The policyholder shall also inform the insureds on the main points of the contract.
3. The policyholder is responsible for notifying cases of incapacity, in accordance with Article 12, para 2a. To this end, the policyholder shall complete the form for the notification of insured events, made available by the Insurer.
4. The policyholder shall notify the Insurer immediately of the end of employment relationship of an employee who has an incapacity.
5. For the final invoicing, the policyholder shall provide the Insurer with the salary declaration form and, if requested, the insureds' AVS/AHV statements. If the salary declaration form is not sent within 30 days of the Insurer's request, the latter shall send the policyholder a formal notice. If the formal notice has no effect, the Insurer shall then assess the rate itself, increasing the premium charged the preceding year. Article 19 of these General Terms and Conditions applies *mutatis mutandis* to the supplemental premium.
6. The policyholder shall afford the Insurer, or the authorized third parties, access to the company's books and accounting documentation, and to the documentation sent to the AVS/AHV Compensation Fund, failing which the Insurer reserves the right to suspend coverage and entitlement to benefits.
7. The policyholder undertakes to provide, automatically or at the Insurer's request, any document capable of establishing the 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 shall notify the Insurer of any event liable to aggravate risks (e.g. change in corporate business activities or of insured professional activity).

Art. 24 Obligations of the insured

1. During the period of incapacity, the insured person shall remain available for any necessary administrative or medical investigations of the Insurer (such as be examined by a doctor designated by the Insurer).
2. The insured shall provide to the Insurer, automatically or at the Insurer's request, any document that is necessary for determining the entitlement to benefits (power of

attorney, medical documents, decision and/or statement of benefits from other insurers, etc.). He shall also notify the Insurer immediately of any changes in circumstances which could affect his entitlement to benefits (change in the degree of incapacity, registration to unemployment insurance, entitlement to third party benefits, etc.).

3. The insured shall release his attending practitioners from medical and professional secrecy vis-à-vis the Insurer's medical advisor.
4. The insured must cooperate with the Insurer and with the third parties mandated by the Insurer (claims' inspectors, other employees, doctors, etc.). He shall follow their instructions, provide the requested documents and answer any questions, fully and truthfully.
5. The insured must submit an application for benefits to the AI/IV disability office no later than six months from the beginning of the incapacity or, upon request of the Insurer, to another social institution.
6. The insured is obliged to limit damages, including cooperate with social insurance institutions (disability insurance, accident insurance, military insurance, etc.).
7. At the latest three days following the beginning of the incapacity, the insured shall consult a licensed doctor at his practice and follow his instructions.
8. 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.

Art. 25 Third-party benefits

1. If a third party reduces its benefits as a penalty, the Insurer shall not compensate the ensuing reduction.
2. If the insured concludes an agreement, without the Insurer's consent, by virtue of which the insured fully or totally renounces the benefits or compensation due from a third party liable for benefits, the Insurer's contractual benefits will be reduced accordingly.
3. Within the limits of the entitlement to benefits, the Insurer shall continue advancing benefits until the Federal Disability Insurance (LAI/IVG), an accident insurance (LAA/UVG), the military insurance (LAM/MVG), a pension fund (LPP/BVG) or a private or foreign insurer establishes that the insured 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 claim restitution of the advances paid directly from the latter during the period conferring entitlement to a pension.
4. Referring to agreements regulating the free transfer of coverage, the duration of any daily allowances benefits paid by preceding insurers shall be deducted from the maximum entitlement to benefits.

Art. 26 Excess benefits

The Insurer's benefits, or the conjunction of such benefits with those paid by other insurers, shall not result in excess benefits for the insured person. Excess benefits must be refunded to the Insurer.

Art. 27 Assignment and pledging of benefits

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

Art. 28 Broker clause

If the policyholder designates a broker, the latter will conduct the business transactions with the Insurer. The broker will forward all requests and answers from one party to another, except for payments. Information is considered to have reached the policyholder once it has reached the broker.

Art. 29 Notices

1. Notices shall be addressed to the Insurer's headquarters or to one of its official agencies.
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.

Art. 30 Place of performance

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

Art. 31 Jurisdiction

In case of dispute, the insured may choose the jurisdiction of the courts of his place of residence in Switzerland, or of the Insurer's registered office or, if the insured is domiciled abroad, that of his place of employment in Switzerland.