groupemutuel

# General terms and conditions for daily allowance

**PI**

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

## A. General

### Art. 1 Purpose of the insurance

The insurer agrees to insure the economic consequences of incapacity resulting from illness or accident, provided these risks are covered by the policy. Benefits are not paid during maternity leave.

### Art. 2 Legal bases

The contract is based on:

1. These general terms and conditions of insurance, the policy and any addendums thereto.
2. The statements made in the insurance proposal and any other statements of the insured person, as well as the health questionnaire.
3. The Federal Law on Insurance Contracts (LCA/VVG).
4. The Federal Law on Data Protection (LPD/DSG)
5. The Swiss Code of Obligations (CO).

### Art. 3 Definitions

**1. Laws:**

| | |
|---|---|
| LAVS/AHVG: | Federal Law on Old-Age and Survivors Insurance |
| LAI/IVG: | Federal Law on Disability Insurance |
| LPP/BVG: | Federal Law on Occupational Retirement, Survivors' and Disability Pension Plans |
| LAMal/KVG: | Federal Law on Health Insurance |
| LAA/UVG: | Federal Law on Accident Insurance |
| LAM/MVG: | Federal Law on Military Insurance |
| LAPG/EOG: | Federal Law on Compensation for Loss of Income |
| LAFam/FamZG: | Federal Law on Family Allowances |
| LACI/AVIG: | Swiss Law on Compulsory Unemployment Insurance and Insolvency Benefits |

**2. Health impairment:**
The term "health impairment" encompasses illnesses and/or accidents.

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

**4. Accident:**
Accident means any harmful, sudden and involuntary, medically and objectively detectable, injury to the human body which is prejudicial to physical, mental or psychological health or results in death and was occasioned by an extraordinary external cause.

Are also equated with accidents, sequels and relapses from accidents, bodily injuries equated with accidents and occupational illnesses within the meaning of the LAA/UVG.

**5. Incapacity:**

Unless otherwise provided, incapacity applies both to incapacity for work and earning incapacity.

**6. Incapacity for work:**

Incapacity for work refers to the loss, in whole or in part, of the insured person's ability to perform the usual duties of the profession practised that may reasonably be required of him, if the loss results from an impairment to his physical, mental or psychological health. As soon as it is no longer possible to return to one's usual occupation, entitlement to benefits will depend on the degree of earning incapacity.

**7. Earning incapacity:**

a. Earning incapacity means any reduction, in whole or in part, of an insured person's earning capacity within a balanced labour market.
b. Only the medical limitations due to the health impairment are taken into account to assess the existence of an earning incapacity.
c. Earning incapacity is determined by the difference between the income earned before the incapacity for work in one's previous profession and the average income that, from a medical point of view, could be earned in another activity, taking into account the level of competency of the insured person, according to the existing Swiss Earnings Structure Survey (ESS).

**8. Insurance case:**

An insurance case is defined as incapacity caused by one or more health impairments that may occur during the same period of disability.

**9. Relapse:**

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

## B. Scope of insurance

### Art. 4 Insurance policy

The insurance policy sets out the details of the insurance coverage, including the insured risks, the amount of the daily allowance, the waiting period and the duration of benefits.

### Art. 5 Eligibility

1. Any person domiciled and gainfully employed in Switzerland, aged between 15 and 55 years, can take out daily allowance insurance.
2. Free transfer to individual coverage
   a. A person who leaves a group daily allowance insurance policy taken out with the insurer may transfer to this individual insurance policy subject to the terms and conditions of the group insurance.
   b. Free transfer only concerns the risks of illness and accident.
   c. As part of free transfer, the cross-border worker with gainful employment in Switzerland or the person domiciled in Switzerland who has not yet reached AVS/AHV retirement age can also make a request for free transfer to individual coverage.
3. With the exception of transferring persons, a health examination is required.

### Art. 6 Territorial and temporal validity

1. **Territorial validity**
   Insurance coverage is granted as long as the insured person is domiciled in Switzerland. For insured persons residing abroad, coverage continues to be granted as long as the insured person can prove that his income originates from gainful employment in Switzerland.
2. **Temporal validity**
   The person who is fully or partially unable to work when the insurance contract comes into effect is not insured. This person will be covered as soon as he has recovered full ability to work for at least 30 days. Cases of free transfer are reserved.

## C. Beginning and end of contract

### Art. 7 Beginning and end of contract

1. Beginning of contract
   The policy indicates the effective date as well as the expiry date, which is 31 December of a calendar year.
2. Automatic renewal of the contract
   Upon termination of the contract and unless the contract is terminated by registered letter no later than 30 September of the current calendar year, it will be automatically extended from year to year.
3. End of contract
   The contract ends:
   a. upon termination of the gainful employment;
   b. in the event of non-payment of premiums, in accordance with Art. 18 para. 3 of these general terms and conditions of insurance;
   c. when the insured person residing abroad can no longer prove that he receives income from a gainful activity in Switzerland;
   d. in the event of termination (including for good cause within the meaning of the LCA/VVG);
   e. when the maximum entitlement to benefits is exhausted;
   f. at the end of the month during which the insured person reaches AVS/AHV retirement age.
   The insurer is not entitled to termination at the end of the term of the contract in accordance with Art. 35a LCA/VVG.

### Art. 8 Termination following a claim

1. After each claim for which a benefit is due from the insurer, the insured person has the right to withdraw from the contract at the latest 14 days after having become aware of the payment of the allowance. If the insured person withdraws from the contract, the insurance shall cease to be effective 14 days after the notice of termination has

been sent to the insurer. The insurer shall remain entitled to 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.
2. The insurer is not entitled to termination following a claim.

### Art. 9 Fraudulent claim

The insurer may cancel or terminate the policy when the insured person has made or attempted to make illegal profits causing the insurer prejudice.

## D. Insurance coverage

### Art. 10 Beginning and end of insurance coverage

1. Coverage begins when the policy takes effect.
2. Insurance coverage ceases in one of the following cases:
   a. at the end of the contract in accordance with Article 7, para. 3;
   b. if the contract is suspended.

   About the entitlement to benefits, Art. 15 of these general terms and conditions of insurance shall apply.

## E. Insured benefits

### Art. 11 Terms and conditions

1. Daily allowance benefits are granted in proportion to the degree of incapacity, which must be at least 25%. Days with a lower degree of incapacity are not taken into account in calculating the duration of benefits and waiting period.
2. Each day of partial incapacity is paid as a full day.
   Each full or partial incapacity must be notified to the insurer within 15 days following its occurrence. After this time limit, the day of receipt by the insurer is deemed the first day of incapacity, subject to Art. 19 para. 11 of these general terms and conditions of insurance.
   If the notification was made late for excusable reasons, the payment of daily allowance benefits is limited to 180 days preceding the day of the notification.
3. If the initial certificate retroactively certifies the start of the incapacity (backdated certificate), the insurer reserves the right, in case of doubt, to consider the first day of incapacity at the earliest three days before the first visit to the medical practice, subject to Art. 19 para. 11 of these general terms and conditions of insurance.
4. The insurer will pay compensation for an incapacity which is medically certified and proved. A doctor's certificate, based on regular medical visits, must be sent to the insurer at least once a month.
5. Daily allowances benefits are covered by indemnity insurance. Compensation cannot exceed the actual loss of earnings.
6. The insurer will pay compensation for an incapacity only when the loss of salary or loss of earnings originates from gainful employment in Switzerland.
7. Daily allowance benefits are paid to a bank or post office account opened in Switzerland, in the currency of the policy.
8. For relapses, the days of incapacity for work taken into account prior to this contract, either by preceding insurers, or within a group insurance, will be deducted from the maximum term of entitlement to benefits as provided for by the general terms and conditions of insurance.
9. The insured person cannot try to prevent the exhaustion of his entitlement to daily allowance benefits by renouncing his right to a daily allowance. Should this be the case, benefits will be paid at the discretion of the medical adviser.

### Art. 12 Waiting period

1. The daily allowance due is payable on expiry of the agreed waiting period, for each day of incapacity (Sundays and public holidays included).
2. 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.
3. The waiting period applies to each incapacity. In case of a relapse, only the possible residual waiting period will be applied.
4. The waiting period is deducted from the term of entitlement to benefits.

### Art. 13 Benefits abroad

1. Subject to paragraph 3, during a stay abroad, or outside the vicinity of the home for cross-border workers (radius of 100 km), no benefits are paid.
   Benefits will be granted upon the duly certified return of the insured person to Switzerland, or in the vicinity of the home of the cross-border worker. However, benefits are granted during the period in which the insured is hospitalised provided that repatriation is not possible.
2. The insured person working abroad for a Swiss employer and the insured person who is abroad for training purposes while being paid by his Swiss employer, will be entitled to daily allowance benefits. Insurance coverage and entitlement to benefits will end after 24 months.
3. During his incapacity for work, the insured person who wishes to travel abroad or to settle there, or the cross-border worker who wishes to leave the vicinity of his place of residence, must inform the insurer prior to departure. After assessing the circumstances, the insurer may decide to continue paying daily allowance benefits. In the absence of an agreement with the insurer, benefits abroad will be refused.

### Art. 14 Limitation of entitlement to benefits

1. Benefits will be refused:
   a. if there is an exclusion or in case of non-disclosure;
   b. if the incapacity is the result of voluntary plastic surgery not covered by the compulsory health insurance;
   c. in case of incapacity due to earthquakes;
   d. in case of incapacity due to events of war
      – in Switzerland;

– abroad, unless events caught the insured person by surprise in the country where he was staying and provided the incapacity occurs no later than three months after the start of these events,

e. in case of fraud or attempted insurance fraud;
f. for health damages caused by ionising rays and damage caused by nuclear radiation, except for health impairments resulting from medical treatment;
g. in case of incapacity during military service abroad;
h. In the event of incapacity for work due to a health impairment caused by the insured person (attempted suicide or voluntary self-mutilation).

2. Benefits may be reduced or refused:
   a. If the accident is caused by the fault of the insured person, in the event of extraordinary dangers or hazardous activities within the meaning of the LAA/UVG.
   b. Benefits may be reduced or, in serious cases, refused altogether if the insured person fails to comply with his obligations under Article 19 of these general terms and conditions.
   c. Benefits may be reduced temporarily or definitively if the insured person refuses to comply with the insurers' instructions (e.g. to be examined the medical expert designated by the insurer) or to provide all information on the facts which could serve, to his knowledge, to determine the entitlement to benefits. The insured person must reply exhaustively and truthfully to the questions asked by the insurer.
   d. if the insured person does not respect the obligation to reduce damages, the insurer may reduce compensation to the amount it would have been reduced to if the obligation had been fulfilled.
3. During periods of suspension for non-payment of premiums as defined in Art. 18 of these general terms and conditions of insurance:
   – Claims that have occurred are not covered.
   – For ongoing claims, payment will resume on the date on which the outstanding premiums are paid, together with interest and costs. In this case, the days of incapacity are deducted from the duration of entitlement to benefits.
4. Entitlement to benefits shall be suspended as long as the insured person is receiving benefits from the federal maternity insurance under the Federal Law on Compensation for Loss of Income (LAPG/EOG) or the cantonal maternity insurance.
   If the insured person is not receiving benefits from the federal maternity insurance under the Federal Law on Compensation for Loss of Income (LAPG/EOG) or the cantonal maternity insurance, the entitlement to benefits is suspended for 56 days after the birth if the pregnancy lasted at least 23 weeks

### Art. 15 End of entitlement to benefits

Entitlement to benefits ends in one of the following cases:

a. upon termination of the insurance contract, subject to the ongoing case not being taken over by another insurer;
b. when the maximum entitlement to benefits is exhausted;
c. in the event of non-payment of premiums in accordance with Art. 18 of these general terms and conditions;
d. at the end of the month during which the insured person reaches AVS/AHV retirement age.

## F. Premiums

### Art. 16 Calculation of the premiums

1. Premiums are calculated based on the insured amount and according to the insured person's age group.
2. An insured person who reaches the last year of his age group is automatically transferred into the next age group at the beginning of the following calendar year.
3. The relevant age groups are:
   – 15 to 20 years;
   – from age 21, age groups are graduated in five-year brackets.
4. The insurer shall inform the insured person of the new rate no later than 25 days before the end of the current year. The adjustment of the premium when moving to a higher age group is deemed to be approved if the insurer has not received any notice of termination before the end of the calendar year.

### Art. 17 Adjustment of the premium rate

1. The premium rate may be adjusted for each calendar year due to, for example:
   – the trend in the cost of claims and/or administrative costs;
   – changes in the range of social insurance benefits covering loss of income/earnings.
2. Premiums shall be adjusted as of 1 January of each calendar year.
3. The insurer shall inform the insured person of the new premium rate no later than 25 days before the expiry of the current year. In the event of a premium increase, if the insured person disagrees, he may request termination of the contract at the end of the current year.
4. Changes are considered approved if the insurer has not received any notice of termination before the end of the calendar year.

### Art. 18 Payment of premiums

1. The insured person is the debtor of the premiums.
2. If the premium is not paid when due, the insurer shall send a formal notice to the debtor, including costs, requesting payment within 14 days of the notice and pointing out the consequences of late payment. If the premium arrears and costs are not paid within the time limit, the insurer's obligations shall be suspended on expiry of this time limit.
3. If the insurer does not institute debt collection proceedings for the premium arrears and costs within two months of the expiry of the 14-day time-limit, the contract is deemed terminated.

## G. Other provisions

### Art. 19 Obligations of the insured person

1. The insured person undertakes to report each case of incapacity for work within 15 days of its occurrence and to

provide the insurer, automatically or at the insurer's request, with all documents that may establish entitlement to benefits (power of attorney, medical documents, decision and/or statement from other insurers, etc.).
These documents must be drawn up in one of the four Swiss national languages or in English. If not, they must be supported by a reliable translation. The insured person must also immediately notify the insurer of any changes in circumstances that may affect the entitlement to benefits (change in the degree of incapacity, registration to the unemployment insurance fund, entitlement to third-party benefits, etc.).

2. During the incapacity for work, the insured must remain available for administrative and medicals check-ups on the part of the insurer.
3. The insured person shall release doctors from medical and professional secrecy vis à vis the insurer's medical adviser.
4. The insured person must cooperate with the insurer and with the third parties appointed by the insurer (claims inspector, officers, doctors, etc.). The insured person shall follow the insurer's instructions, provide the requested documents and answer any questions. If the insured fails to appear for an examination without good reason, the insurer reserves the right to reduce or refuse benefits, or to demand that any benefits already paid be refunded and to bill the insured for the missed medical appointment.
5. The insured person 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 insurance office. If the insured fails to do so, or does not do so in good time, daily allowance benefits are suspended until the date of the application for benefits.
6. The insured person is obliged to limit damages, including cooperate with social insurance institutions (disability insurance, accident insurance, military insurance, etc.).
7. Within reasonable limits, the insured shall participate in treatment or in professional retraining measures designed to significantly improve his capacity for work or offer new earning prospects.
8. 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.
9. In case of fraud or insurance fraud attempts, the insured person will be required to pay for the investigation expenses incurred by the insurer for verifying the incapacity as well as for following up the case.
10. Failure to comply with these obligations may result in sanctions by the insurer, which may include the refusal of benefits, pursuant to Art. 14, para. 2 of these general terms and conditions of insurance.
11. The sanctions shall not apply if the breach of duty is not due to a fault or if the insured person can prove that the breach of duty had no influence on the occurrence of the event and on the scope of benefits.

## Art. 20 Third party benefits

1. The insurer subsidiarily covers the insured person's loss of salary or loss of earning benefits which are not covered by any other social insurer.
2. If a third party reduces its benefits due to a sanction, the insurer shall not compensate the ensuing reduction.
3. If several private insurers cover the loss of earnings, the aggregate benefits paid by them cannot exceed the loss suffered. In the event that several indemnity insurance policies are involved, the insurer will compensate the loss of earnings or loss of salary benefits pro rata to the insured daily allowance proportionately to the share of the total insured benefits. In the event of overlapping with a fixed-sum insurance, the insurer shall intervene subsidiarily.
4. Upon occurrence of the insured risk, the insurer is subrogated, within the limits of the contractual benefits, to the rights of the insured person and his/her survivors against any liable third party.
5. If the insured person concludes an agreement, without the insurer's consent, by virtue of which the insured person fully or totally renounces the benefits or compensation due from a third party liable for benefits, the insurer's contractual benefits will be reduced accordingly.
6. Within the limits of the entitlement to benefits, the insurer shall continue to pay benefits in advance until the Federal Disability Insurance (LAI/IVG), accident insurance (LAA/UVG), military insurance (LAM/MVG), a pension fund (LPP/BVG) or a foreign or private insurer establishes that the insured person is entitled to a pension. As soon as a pension is granted by one or more of the aforesaid institutions, the insurer shall be entitled to request reimbursement of the advances granted directly from the latter or from another third party. The repaid amount shall vest with the insurer.
7. For the purpose of calculating the duration of benefits, days on which benefits are reduced or on which the insurer is not required to pay anything because of third party benefits, will count as full days.

## Art. 21 Excess benefits

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

## Art. 22 Assignment and pledging of benefits

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

## Art. 23 Compensation

1. The insurer may offset benefits due against amounts receivable from the insured person.
2. Insured persons are not allowed to offset benefits against the insurer.

## Art. 24 Adjustment of insurance conditions

1. The insurer is entitled to adjust these general terms and conditions, in particular if there are changes in the scope of social insurance benefits.

2. The new terms and conditions apply to policyholders and to the insurer if they are adjusted in accordance with the first paragraph during the term of validity of the insurance.
3. The insurer shall notify the policyholders of these adjustments. If the policyholder does not accept the changes, he may terminate the 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 have been accepted.
4. Exceptions to the right of termination are adjustments to the terms and conditions of insurance that do not result in any disadvantage for the insured person.

## Art. 25 Notices

1. All notices from the policyholder must be sent to the postal or email addresses indicated on the insurer's official documents, in writing or by any other means made available by the insurer, excepted social networks.
2. Notices from the insurer are valid if they are sent to the last postal or email address communicated to the insurer by the policyholder. These notices may be sent in writing or by any other means that can be proven by a text.
3. The insurer may also send general communications to policyholders via the magazine for its insured persons. The insured person who no longer wishes to receive the magazine may so request in writing from the insurer, or by any other means made available by the insurer, in which case the insurer shall not be liable for the communications published. These communications may also be made on the insurer's website and in a document enclosed when sending out annually the insurance policies.

## Art. 26 Place of performance

The obligations arising from the contract shall be performed in Switzerland and in Swiss francs.

## Art. 27 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, those of his place of work in Switzerland.

## Art. 28 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 in particular to information relating to the persons concerned, which includes in particular information relating to the management of the insurance contract. Sensitive data refers in particular to information relating to the state of health of insured persons and to 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 it 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 LPD/DSG); the contract concluded between Groupe Mutuel and the persons concerned; the overriding public interest or the overriding private interest of Groupe Mutuel or the persons concerned, within the meaning of the LPD/DSG.

**Purposes**

Personal and sensitive data are used in particular to assess the risks to be insured, process claims, ensure the administrative, statistical and financial follow-up of the contract, allow the management of Groupe Mutuel's activities (statistics, internal and external audit, etc.) and compliance with its legal obligations, the improvement and development of services provided, the optimisation and cost-effectiveness of insurance costs, prospecting and marketing operations, the management of unpaid debts and disputes, the fight against fraud, money laundering, terrorist financing and tax fraud. To this end, this data may be communicated, shared and exchanged between Groupe Mutuel and third parties (see below). Data used for statistical purposes is made anonymous.

**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 shall 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.

**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.