Collective daily allowance insurance in case of illness under LCA/VVG

Edition: 01 Sept 2016

Practical and legal information in accordance with the Federal Law on Insurance Contracts (LCA/VVG)

The following document for clients provides a clear and concise overview of the identity of the Insurer and the most important points of the insurance contract, as required by Article 3 of the Federal Law on Insurance Contracts (LCA/VVG).

Who is the Insurer?
The contractual partner is Mutuel Assurances SA (hereafter «the Insurer»), whose headquarters are at Rue des Cèdres 5, P.O. Box, CH -1919 Martigny.

What risks are insured and what is the scope of the insurance cover?
The insurance covers the economic consequences of incapacity arising from illness, which means any medically and objectively discernible involuntary impairment of a persons' physical, psychological or mental health which was not caused by an accident or the sequels of an accident, and which requires a medical examination or treatment or gives rise to incapacity. Pregnancy complications are equated with an illness.

Depending on the provisions in the policy, 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, is objectively detectable and was occasioned by an extraordinary external cause.

Depending on the provisions in the policy, insurance coverage may also provide for the payment of supplemental maternity allowance.

Insurance coverage applies to incapacity for work, namely full or partial loss of the insured person's capacity to perform work which could reasonably be expected of him within the limits of his profession or area of activity.
In case of incapacity for work exceeding six months, the entitlement to benefits is based on the earning incapacity, namely any reduction, be it full or partial, of an insured's earning capacity within a balanced labour market.

The policyholder may choose between the two following coverage options:
Alternative 1: The Insurer pays the daily allowance agreed in the policy for a maximum of 730 days, in LPP/BVG coordination. Any waiting period will be deducted from the term of entitlement to benefits.
Alternative 2: The Insurer pays the daily allowance agreed in the policy for a maximum of 730 days within a period of 900 consecutive days for one or several cases of incapacity. Any waiting period will be deducted from the term of entitlement to benefits.
Claims for cases arising during the term of collective coverage shall be charged to the collective policy.

The scope of insurance benefits is set out in the General Terms and Conditions of Insurance.

The insurance policy sets out the start and end of the insurance contract, the insured risks (illness, accident, maternity), the amount of the maximum salary considered for calculating the benefits, the percentage of the insured salary, the selected coverage option and waiting period, as well as any special terms and conditions of insurance.

What are the premium rates?
Premiums rates are based on the insured risks and agreed coverage. The premium is calculated based on the premium rates and the salaries indicated by the employer.

Who is the policyholder and who are the insured persons?
The policyholder is the employer who concluded the insurance contract.
Insured persons may include:
- employees;
- the owner of a sole proprietorship and his family members if they are mentioned by name in the policy;
- the shareholders mentioned in the policy.

What are the obligations of the policyholder?
The obligations of the policyholder are set out in the insurance policy and in the General Terms and Conditions of Insurance.

The policyholder shall inform the insured persons of the main contents of this contract and of its amendments and termination. For this purpose, he will receive documents from the Insurer.

Mutuel Assurances SA
Rue des Cèdres 5
P.O. Box - CH-1919 Martigny
Phone 0848 803 777 - www.groupemutuel.ch

The policyholder shall also inform the insured persons of the possibility of maintaining insurance coverage in case of departure from the circle of insureds or on expiry of the policy.

Furthermore, the policyholder must fulfil the following obligations:
- notify the Insurer of cases of incapacity for work **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 insured persons' AVS/AHV statements;
- 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).

The obligations of the policyholder are set out in the General Terms and Conditions of Insurance.

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;
- cooperate with the Insurer and with other social insurance institutions;
- make all efforts to limit damages;
- inform the Insurer before travelling abroad, in the cases provided for in Article 16, paragraph 3 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?
The insurance coverage can be reduced or refused in the following cases (non-comprehensive list):
- if the policyholder or the insured does not respect his obligations as provided for in the terms and conditions of insurance;
- if the incapacity for work is not notified to the Insurer within 15 days of its occurrence;
- if the initial certificate was issued more than three days after the start of the incapacity;
- if the insured person refuses to cooperate with the Insurer or other social insurance institutions;
- **in case of fraud or insurance fraud attempts;**
- if the insured person fails to appear for a medical examination without good reason, the Insurer may also demand that any benefits already paid be refunded and bill the insured for the missed medical appointment;
- during a stay abroad, in the case provided for by Article 16 of the General Terms and Conditions of Insurance;
- if premiums are not paid by the policyholder;
- if there is an exclusion;
- if the incapacity is the result of voluntary plastic surgery not covered by the compulsory health insurance;
- for the consequences of events of war, in the cases provided for by Article 18, paragraph 1, letter (d) of the General Terms and Conditions of Insurance.

The limitations of coverage are set out in the General Terms and Conditions of Insurance.

When does the contract begin?
The contract is concluded once the Insurer has notified acceptance of the proposal.

When does the insurance contract end?
The policyholder can terminate the contract in the following cases:
- on expiry of the contract as set out in the policy, subject to three months' written notice;
  The notice of termination shall be deemed valid if it is received by the Insurer at the latest on 30 September. If the contract is not terminated, it shall be automatically extended for one year at a time.
- after each claim for which a benefit is paid out by the Insurer, at the latest 14 days after having become aware of the payment of the claim by the Insurer;
- if the Insurer changes the premiums;
  In this case, notice of termination must reach the Insurer before the end of the calendar year.
- if the Insurer has not fulfilled its obligation to inform, pursuant to Article 3 LCA/VVG;
  The right of termination lapses four weeks after the insured has received notification of this breach, but at the latest one year after the breach.

The insurance also ends:
- if the company ceases its business activities or if the company goes into bankruptcy;
- following non-payment of premiums;
- when the headquarters or the place of residence of the policyholder is transferred abroad.

The Insurer can terminate the contract in the following cases:
- on expiry of the contract as set out in the policy, subject to three months' written notice;
  If the contract is not terminated, it shall be automatically extended for one year at a time.
- if the policyholder fails to disclose or disclosed inaccurately an important fact;
- following non-payment of premiums;
- in case of fraud or insurance fraud attempts by the policyholder.

These lists only contain the most common possible reasons for termination. The General Terms and Conditions of Insurance and the LCA/VVG contain other possible reasons.

When does the insurance coverage begin?
For each insured, coverage starts on the day of entry into force of the employment contract, but not before the policy comes into effect.

When does the insurance coverage end?
For each insured, insurance coverage ceases:
- at the end of the employment contract;
- if premiums are not paid in accordance with Article 21 of these General Terms and Conditions of Insurance;
- on termination or suspension of the insurance contract;
- no later than the end of the month coinciding with the insured's 70th birthday;
- at the end of the LAA/UVG accident coverage for the worker posted abroad.

When does the entitlement to benefits end?
For each insured, the entitlement to benefits ceases:
- on suspension of the insurance contract following non-payment of premiums;
- when the maximum entitlement to benefits is exhausted;
- at the end of the month coinciding with the insured's 70th birthday;
- at the end of employment lasting three months or less;
- upon termination of the policy, subject to the ongoing case not being covered by another insurer.

How does the Insurer handle data?
The Insurer processes the personal data of the policyholder and insured persons, including data related to the contract, premium collection and claims, with all due confidentiality. Transferring data to third parties is authorised only in accordance with the exceptions provided for by law.

Data of persons abroad can also be transferred to partners domiciled abroad. Data is processed including for the purpose of risk assessment, policy management, premium calculation and claims management. The policyholder and the insured persons autho-rise the Insurer and its representatives to process the necessary data pertaining to their insurance contracts with insurers and/or member companies of Groupe Mutuel, Association d'assureurs. Data is stored in hard copy form and/or electronically.