Collective Accident Insurance (supplementing LAA/UVG coverage)

Edition: 01 Aug 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?

The insurance covers the economic consequences of occupational accidents, meaning all accidents within the meaning of the Federal Law on Compulsory Accident Insurance (LAA/UVG) incurred by an insured person in the scope of his gainful activity. All other accidents are considered non occupational accidents and also form an integral part of the insurance coverage.
The insurance also covers occupational illnesses. Occupational illnesses are defined as illnesses within the meaning of the LAA/UVG which qualify as occupational accidents from the day the employee is taken ill, from the first time he requires medical treatment or from the day he is unable to work.

What benefits are covered by the insurance?

Coverage may be extended to include the following benefits:

- treatment costs depending on the selected option;
- hospital daily allowance;
- daily allowance in case of incapacity for work;
- daily allowance in case of a relapse and/or late consequences from previous accidents which were not covered;
- daily allowance in the event of death within the limits of the entitlement to benefits of the LAA/UVG and the provisions of Article 338 of the Swiss Code of Obligations;
- in case of disability: a lump-sum disability benefit and/or the cost of plastic surgery and/or the cost of professional retraining;
- lump-sum benefit in case of death;
- benefits in the form of an LAA/UVG excess pension;
- coverage of the reduction imposed by the LAA/UVG accident insurance.

The scope of the insurance as well as any restrictions to it are set out in the General Terms and Conditions of Insurance.

What are the premium rates?

The premium rates depend on the insured benefits. Premiums are calculated based on premium rates and on the salaries reported 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/her family members if they are mentioned by name in the policy;
- the shareholders if mentioned in the policy.

Insurance policy:

The insurance policy specifies the insured persons, the amount of the maximum insured salary, the insured benefits and any special terms and conditions.

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 must inform the insured persons of the main contents of this contract, of its amendments and termination, as well as of the possibility of maintaining insurance coverage in case of departure from the circle of insureds or upon expiry of the policy.
Furthermore, the policyholder must fulfill the following obligations:

- notify the Insurer promptly after hearing that one of his employees has had an accident which requires medical attention, causes an incapacity for work or results in the insured's death;
- notify the Insurer immediately of the termination of the employment relationship of an employee who has an incapacity for work;
- provide the Insurer with the salary declaration form for the final invoicing and, if requested, the insureds' AVS/AHV statements;

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

- 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 likely 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 fulfill the following obligations:

- notify his employer or the Insurer promptly of any accident requiring medical attention or causing an incapacity for work.
  If the insured dies as a result of the accident, this obligation is incumbent upon the survivors of the deceased who are entitled to benefits;
- consult a licensed doctor at his practice at the latest three days following the beginning of the incapacity and follow the doctor's instructions;
- cooperate with the Insurer and with social insurance institutions;
- make all efforts to limit damages;
- remain available for any necessary administrative or medical investigations during the period of incapacity for work;
- 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 and 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 Insurer waives its rights to reduce its benefits for all accidents insured by the policy and caused recklessly or through gross negligence within the meaning of the LAA/UVG, subject to the exclusions provided for in the general terms and conditions of insurance.

Cash benefits will be reduced mutatis mutandis to the LAA/UVG insurance:

- when the accident was caused while committing an offence;
- in case of participation in brawls and fights;
- when the insured exposes himself to danger by seriously provoking a third party;
- if the insured participates in disturbances.

Benefits may be reduced or refused temporarily or definitively:

- if either the policyholder or the insured person does not respect his obligations;
- if the insured person refuses to comply with the Insurer's instructions or fails to appear for a medical examination requested by the Insurer;
- if the insured refuses to provide all information on the facts which could serve, to his knowledge, to determine the entitlement to benefits.

Any restrictions to benefits 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.
The policy indicates the effective date.

When does the insurance contract end?

The contract expiry date is 31 December of a calendar year.
The policyholder can terminate the contract in the following cases:

- on expiry of the contract, 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 which a benefit is paid out for 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, the notice of termination must reach the Insurer before the end of the calendar year.

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.

In which case can the Insurer terminate the contract?

- upon expiry of the policy unless, the contract is terminated by the policyholder no later than on 30 September of the current calendar year.
  If the contract is not terminated it shall be automatically extended for one year at a time;
- when the policyholder makes or attempts to make illegal profits causing the Insurer prejudice;
- the Insurer expressly waives his right conferred to him by the LCA/VVG to cancel the contract following loss or damage save in case of abuse, misrepresentation, fraud or non-disclosure, or attempted abuse, misrepresentation, fraud or non-disclosure 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?

Coverage starts from the time the contract is effective but not before the first day of employment, or as soon as the entitlement to the first salary arises, and in any event from the moment the employee sets off to work.

When does the insurance coverage end?
For each insured person, insurance coverage ceases:
- if the insured person departs from the insurance contract: at the end of the day before starting work with a new employer or registration to unemployment benefits, but at the latest at the end of the 31st day following termination of the employee's entitlement to at least half a salary; for part-time workers, who are insured only for occupational accidents and occupational illnesses, coverage ceases on the last day of work.
- following non-payment of premiums;
- at the end of the insurance contract;
- at the end of the LAA/UVG accident coverage for the worker posted abroad.

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 for reasons including for the purpose of risk assessment, policy management, premium calculation and claims management. The policyholder and the insured persons authorise the Insurer and its representatives to process the necessary data pertaining to their insurance contracts with insurers and companies member of or managed by Groupe Mutuel. Data is stored in hard copy form and/or electronically.

Groupe Mutuel
Assurances
Versicherungen
Assicurazioni

Mutuel
ASSURANCES SA
VERSICHERUNGEN AG
ASSICURAZIONI SA

General Terms and Conditions for (CGA) Collective Accident Insurance (supplementing LAA/UVG coverage)

LAACAM06-E2 – Edition: 01 Aug 2016

Table of Contents

A. General principles
Art. 1 Purpose of insurance
Art. 2 Legal bases of the contract
Art. 3 Definitions

B. Scope of insurance
Art. 4 Insurance policy
Art. 5 Insured persons

C. Start and end of contract
Art. 6 Start and end of contract
Art. 7 Termination following a loss
Art. 8 Fraudulent claim

D. Insurance coverage
Art. 9 Start and end of insurance coverage
Art. 10 Transfer to individual coverage
Art. 11 Unpaid leave

E. Insured benefits
Art. 12 Treatment costs (healthcare benefits and reimbursement of costs)
Art. 13 Hospital daily allowance
Art. 14 Daily allowance
Art. 15 Additional guarantees (previous accident and benefits in the event of death)
Art. 16 Disability
Art. 17 Lump-sum in case of death
Art. 18 Benefits in the form of an LAA/UVG excess pension
Art. 19 Coverage of the reduction imposed by LAA/UVG accident insurance
Art. 20 Adjustment of entitlement to benefits when reaching the statutory AVS/AHV retirement age
Art. 21 Territorial validity
Art. 22 Excluded benefits
Art. 23 Reduction and denial of benefits
Art. 24 Recourse against liable third parties

F. Premiums
Art. 25 Payment of premiums
Art. 26 Adjustment of premium rates
Art. 27 Final premium settlement
Art. 28 Surplus-sharing

G. Other provisions
Art. 29 Obligations of the policyholder
Art. 30 Obligations of the insured person
Art. 31 Change in insured risks
Art. 32 Assignment and pledging of benefits
Art. 33 Broker clause
Art. 34 Notices
Art. 35 Place of performance
Art. 36 Jurisdiction

A. General principles

Art. 1 Purpose of insurance

Mutuel Assurances SA is the risk-bearing insurer.
It guarantees to cover the economic consequences of occupational accidents, non occupational accidents and occupational illnesses, according to the benefits set out in the policy, which are covered by LAA/UVG accident insurance, military insurance or by collective accident insurance comparable to LAA/UVG coverage.

Art. 2 Legal bases of the contract

The legal bases of the contract are:

1. These General Terms and Conditions, any supplemental or special terms and conditions as well as the provisions of the policy and relevant annexes, as well as the pre-contractual information.
2. The written statements made in the insurance proposal and any other written statements of the policyholder.
3. The Federal Law on Insurance Contracts (LCA/VVG).
4. The Law on Data Protection (LPD/DSG) which the Insurer duly complies with when processing data.
5. The Federal Law on Accident Insurance (LAA/UVG) applies mutatis mutandis where provided for by these General Terms and Conditions.

Art. 3 Definitions

1. LAVS/AHVG: Federal Law on Old-Age and Survivors Insurance
   LAI/IVG: Federal Law on Disability Insurance
   LAMal/KVG: Federal Law on Health Insurance

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

LAA/UVG: Federal Law on Compulsory Accident Insurance
OLAA/UVV: Ordinance on Accident Insurance
LAM/MVG: Federal Law on Military Insurance
LACI/AVIG: Swiss Law on Compulsory Unemployment Insurance and Insolvency Benefits
CO: Swiss Code of Obligations

2. Occupational accidents
Occupational accidents are defined as accidents within the meaning of the Federal Law on Compulsory Accident Insurance (LAA/UVG) incurred by an insured person in the scope of his gainful activity. All other accidents are considered non occupational accidents.
3. Occupational illnesses
Occupational illnesses are defined as illnesses within the meaning of the LAA/UVG; an occupational illness is equated with an occupational accident from the day the employee is taken ill, from the first time he requires medical treatment or from the day he is unable to work.
4. Incapacity for work
Incapacity for work means 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 for work, the work which could reasonably be expected of the insured may also be work in another profession of area of activity.
5. Disability
Disability is defined as a full or partial earning incapacity that is likely to be permanent or to persist in the long-term.
6. Posted worker
A posted worker is a person subject to compulsory health insurance in Switzerland who is sent abroad temporarily while remaining bound by an employment relationship with an employer officially based or with headquarters in Switzerland and who is entitled to receive a salary.
7. Cross-border worker
A cross-border worker is a person carrying out a gainful activity in a different country than the one which he resides in within the European Union and who returns home at least once a week.
8. Case
Case means the occurrence of occupational illness or a specified accident in a particular individual.
9. LAA/UVG salary
The LAA/UVG salary equates to the insured income within the meaning of the LAA/UVG and its relevant ordinances.
10. Salary exceeding the LAA/UVG limit
The salary exceeding the LAA/UVG limit equates to the salary exceeding the maximum insured income within the meaning of the LAA/UVG and its relevant ordinances.
11. Collective accident insurance comparable to LAA/UVG coverage
The purpose of this insurance is to provide coverage based on the catalogue of benefits of compulsory accident insurance (LAA/UVG).

B. Scope of insurance

Art. 4 Insurance policy

The insurance policy sets out the details of the insurance coverage, including the insured persons, the amount of the maximum salary, the insured benefits and any special terms and conditions.

Art. 5 Insured persons

All persons belonging to the circle of insureds defined in the policy are insured, provided they are subject to LAA/UVG compulsory insurance for the activity defined in the policy.
For part-time workers who are covered by compulsory accident insurance only for occupational accidents and occupational illnesses because of their working time in the insured company, supplemental LAA/UVG coverage is also limited to occupational accidents and occupational illnesses.
For these persons, accidents that occur on the way to work are considered occupational accidents.
Workers who are not subject to LAA/UVG but who are covered under collective accident insurance comparable to LAA/UVG coverage, may also be insured.

C. Start and end of contract

Art. 6 Start and end of 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 of the contract
Unless the contract is terminated by registered letter received by the Insurer 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 will end:
   a. if the company ceases its business activities or if the company goes into bankruptcy;
   b. if premiums are not paid in accordance with Article 25 of these General Terms and Conditions of Insurance;
   c. when the headquarters are or the 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 increase within the meaning of Art. 26 of these General Terms and Conditions.

Art. 7 Termination following a loss

1. The Insurer expressly waives his right, conferred to him by the LCA/VVG, to cancel the contract following loss or damage save in case of abuse, misrepresentation, fraud or non-disclosure, or attempted abuse, misrepresentation, fraud or non-disclosure on the part of the policyholder.
2. After each claim which the Insurer is liable for in terms of benefits, the policyholder may withdraw from the contract within 14 days of hearing that the benefit was paid.

If the policyholder withdraws from the contract, coverage ceases 14 days after the Insurer receives the notice of termination.

Art. 8 Fraudulent claim

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

D. Insurance coverage

Art. 9 Start and end of insurance coverage

Benefits are payable only if the accident, bodily injury or last exposure to danger before the occupational illness was declared to have occured during the validity of the collective insurance coverage, with the exception of Article 15 of these General Terms and Conditions.

Relapses for accidents that occurred during the insurance year are covered provided they are covered by LAA/UVG.

1. Start of insurance coverage
   Coverage starts on the first day of employment or when the entitlement to the first salary arises, and in any event from the moment he sets off to work.
2. End of insurance coverage
   For each insured, insurance coverage ceases:
   a. at the end of the day before starting work with a new employer, or registration to unemployment benefits, but at the latest at the end of the 31st day following termination of the employee's entitlement to at least half a salary, subject to Article 11 of these General Terms and Conditions;
      For part-time workers, who are insured only for occupational accidents and occupational illnesses, coverage ceases on the last day of work.

   The insurance also ends:
   b. if premiums are not paid in accordance with Article 25 of these General Terms and Conditions;
   c. at the end of the insurance contract;
   d. at the end of the LAA/UVG accident coverage for the worker posted abroad, subject to Article 5 of these General Terms and Conditions.

Art. 10 Transfer to individual coverage

1. Right to transfer
   The insured person residing in Switzerland who leaves the circle of persons qualifying for insurance has the right to maintain his coverage on an individual basis. The insured must claim his right of transfer within 90 days of leaving the circle of insureds provided that no accident occurs from the last day of work.
   Right to transfer also applies to the cross-border worker if he is pursuing employment in Switzerland.
2. Terms and conditions of the transfer
   The insurance will cover, at the most, the benefits for medical costs, daily allowance benefits and lump-sums that were insured until then, without a new medical examination. Benefits shall be reduced proportionally if the amount of the new income or unemployment benefits is lower.
   The prevailing general terms and conditions of the individual insurance will apply.
   The age of the insured person upon entering the collective contract is decisive in calculating the premium.
3. Limitation of the right to transfer
   There is no right to transfer to individual coverage in the following cases:
   – if the collective insurance is terminated and coverage is transferred to another insurer for the same circle of insured persons or parts thereof;
   – if the insured leaves his job and is covered under the LAA/UVG supplemental insurance of his new employer;
   – if the insured person is receiving a retirement pension from AVS/AHV insurance or from any other foreign social insurance.

Art. 11 Unpaid leave

1. In case of unpaid leave, coverage shall continue for a maximum of six months, provided the insured person is covered by the LAA/UVG insurance (extended insurance) and his employment contract has not been terminated.
   The employer shall notify the Insurer in written form the departure of the insured person of the name and first name of the employee, his insured salary, as well as the beginning and end of the leave, failing to will make the insurance coverage expire. Retroactive notification will not be accepted.
2. The amount of salaries for the duration of the unpaid leave shall be notified in the salary declaration form at the end of every calendar year. The insured salary is the income the insured person would have received should he not have taken unpaid leave.

E. Insured benefits

Art. 12 Treatment costs (health-care benefits and reimbursement of costs)

If treatment costs are insured, the Insurer will pay, for the relevant coverage and from the date of the accident, the difference between the benefits payable by the LAA/UVG insurer and the benefits listed below.

Treatment must be carried out by recognised practitioners within the meaning of the LAA/UVG.

1. Medical treatment
   Treatment costs including drugs and tests.
   If the care provided in the residence country (European Union member) is covered by the LAA/UVG insurer in accordance with the legal and tariff provisions of the residence country, the excess fees (invoiced for outpatient treatments and by pharmacists who are not reimbursed by the social insurance of the residence country) are covered by the LAA/UVG supplemental insurance.

2. Hospitalisation
   For the insurance class stated in the insurance policy, the cost of treatment, room and board in a Swiss hospital facility recognised by the Insurer, including the deduction made by the LAA/UVG insurer for room and board costs.
3. Convalescence and other cures
   Prescribed treatment in a cure centre or convalescence facility recognised by the Insurer. Additional cost for room and board are covered in addition to the LAA/UVG insurer up to CHF 200 per day, for a maximum of 30 days per stay, up to maximum 120 days for the same accident.
4. Alternative medicine
   The cost of the following therapies, provided they are administered by a qualified doctor or a natural therapy practitioner recognised by the Insurer, up to CHF100 per session, for a maximum of CHF 2,500 per case.
5. Medical aids and appliances
   The costs of the first acquisition of appliances which are designed to compensate a physical injury or the impairment or loss of a function (prosthesis, spectacles, hearing devices and orthopaedic auxiliary appliances). The repair or replacement cost (new value) of aids and devices designed to physically or functionally replace a body part provided such aids or devices were damaged or destroyed during an insured accident which caused the insured a physical injury necessitating treatment.
6. Home help and home care
   The insured person is entitled to home help and home care prescribed by a doctor, provided they are provided by an organisation recognised by the Insurer.
   Home help is provided if an insured has a medically certified incapacity of at least 50%.
   Home care is covered within the limitations below and for as long as the insured person is receiving a daily allowance benefit from the LAA/UVG insurer.
   The limitation for home help and home care is CHF 100 per day, at a maximum of CHF 6,000 per case.
7. Transport costs
   The cost of transporting the insured to the place of treatment will be reimbursed for the duration of the treatment. If justified on medical or technical grounds, air transport costs will be reimbursed.
8. Body transport costs
   The cost of transporting the body to the place of burial is reimbursed if the insured died as a result of an insured accident.
9. Search operations
   The Insurer shall pay in addition to the LAA/UVG insurance the necessary costs for search operations, up to CHF 30,000 per insured.
10. Third-party services
   If treatment costs under this article are payable by any other insurance, the Insurer shall pay supplemental benefits up to the total cost of treatment.
11. Excess benefits
   If treatment costs are covered by several insurance contracts taken out with recognised insurers, the aggregate benefits may not exceed the actual total costs resulting from the accident. The Insurer is only liable proportionately to the ratio that the benefits insured by it bears to the total benefits insured by all insurers.

Art. 13 Hospital daily allowance

1. Entitlement
   The Insurer will pay the daily allowance stated in the policy for the length of the insured's hospitalisation or cure provided that the hospitalisation or cure is medically necessary and was prescribed by a doctor.
   The hospital stay is medically necessary if the related medical treatment assists in improving the health impairment or in preventing an unfavourable development of the latter.
   In addition, the stay in a medically controlled convalescence centre will only be covered if the insured was following a medical treatment before the beginning of the cure.
   When care is provided at home upon medical prescription in order to avoid a hospital stay, the Insurer will pay the corresponding daily allowance to the insured.
2. Duration of benefits
   The hospital daily allowance is paid from the first day of the accident:
   - for hospital stays, during a maximum of 360 days per case;
   - for cure or convalescence stays, during a maximum of 30 days per stay, up to 120 days for the same case;
   - if care is provided at home, half of the agreed daily hospital allowance is paid by the Insurer during a maximum of 200 days of home care per case.

Art. 14 Daily allowance

Provided the insured was entitled to a daily allowance benefit under the LAA/UVG insurance, the Insurer shall provide the insured with a medically certified incapacity for work, the agreed daily allowance benefit agreed in the policy, subject to Article 19(a) of these General Terms and Conditions.
The insured daily allowance is payable on expiry of the agreed waiting period.
The waiting period begins on the day following the day the accident occurred.
Upon receipt of an interim or final medical certificate, the Insurer will indemnify the insured until the date stated on the practitioner's certificate but not beyond the end of the current month unless the Insurer requests an additional medical examination.

1. Partial incapacity for work
   In case of a partial incapacity for work, the Insurer will pay a daily allowance reduced pro rata the degree of incapacity for work.
   In calculating the waiting period, each day of partial incapacity for work counts as a full day.
2. Third-party services
   If the insured is also entitled to benefits from the federal disability insurance or any other social insurance, the Insurer shall pay supplemental benefits up to the insured's actual loss of earnings. The Insurer shall pay no more than the stated daily allowance.
3. Excess benefits
   If the daily allowance is covered by several insurance contracts taken out with recognised insurers, the insured shall only be compensated once for his total loss of earnings. The Insurer is liable proportionately to the ratio that the benefits insured by it bears to the total benefits insured by all insurers.

Art. 15 Additional guarantees (previous accident and benefits in the event of death)

If provided for by the policy, coverage will extend to the following benefits:

1. In case of a relapse and/or late consequences from a previous accident which were not or are no longer covered by the insurance, the Insurer will pay, in case of a recognised incapacity for work, a daily allowance benefit up to 80% of the insured income based on the LAA/UVG salary. The duration of benefits is limited, per case, to 180 days or more if provided for by the employer's statutory obligation within the meaning of Article 324(a) of the Swiss Code of Obligations (CO).
   The entitlement to a daily allowance arises on the third day following the day on which the incapacity for work was confirmed. Days of partial incapacity for work are counted as full days in calculating the duration of benefits.
2. In the event of the insured person's death following an insured accident, the Insurer will pay a daily allowance benefit of up to 80% of the insured income based on the LAA/UVG salary according to the terms and conditions provided for in Article 338 CO.
3. If daily allowance coverage is provided for in the policy, it will also be taken into account for the calculation of benefits within the limits of the maximum insured salary.

Art. 16 Disability

If provided for by the insurance policy, the Insurer pays, depending on the selected coverage:

– a lump-sum disability benefit (in accordance with item 1(c) here below); and/or,
– the cost of plastic surgery (in accordance with item 2 here below); and/or
– the cost of professional retraining (in accordance with item 3 here below).

1. Lump-sum benefits:
   a. Entitlement to benefits
      A lump-sum disability benefit will be paid as soon as the disability is recognised as being permanent and subject to Article 20(2) of these General Terms and Conditions.
   b. Degree of disability
      The degree of disability is set in accordance with the scale of impairment in Annex 3 of the Ordinance on Accident Insurance (OLAA/UVV) and in accordance with SUVA's tables.
      In case of a partial functional disability, the percentage is reduced proportionally. If the degree of disability cannot be established in accordance with the rules above, it will be set by analogy taking into account the seriousness of the impairment based on the medical report. If several organs or parts of the body are affected by the same accident, the relevant percentages will be weighted. Notwithstanding, the degree of disability cannot exceed 100%.
   c. Calculation of the lump-sum capital
      The lump-sum capital in case of disability is calculated based on the degree of disability, the agreed insured sum and the chosen progression.
      If the insured was already disabled before the accident, the lump-sum capital payable by the Insurer is proportionate to the disability directly caused by the accident.
   d. Progression
      In the case that progressive disability lump-sum capital was chosen, the disability lump-sum capital is calculated in function of the degree of disability and the chosen progression in accordance with the following table:

Benefits in % of the insured sum

Disability level %	Compensation according to variants no progression	A	B
100	**100**	**225**	**350**
99	99	222	345
98	98	219	340
97	97	216	335
96	96	213	330
95	**95**	**210**	**325**
94	94	207	320
93	93	204	315
92	92	201	310
91	91	198	305
90	**90**	**195**	**300**
89	89	192	295
88	88	189	290
87	87	186	285
86	86	183	280
85	**85**	**180**	**275**
84	84	177	270
83	83	174	265
82	82	171	260
81	81	168	255
80	**80**	**165**	**250**
79	79	162	245
78	78	159	240
77	77	156	235
76	76	153	230
75	**75**	**150**	**225**
74	74	147	220
73	73	144	215
72	72	141	210
71	71	138	205
70	**70**	**135**	**200**
69	69	132	195
68	68	129	190
67	67	126	185
66	66	123	180
65	**65**	**120**	**175**
64	64	117	170
63	63	114	165

Disability level %	Compensation according to variants no progression	A	B
62	62	111	160
61	61	108	155
60	**60**	**105**	**150**
59	59	102	145
58	58	99	140
57	57	96	135
56	56	93	130
55	**55**	**90**	**125**
54	54	87	120
53	53	84	115
52	52	81	110
51	51	78	105
50	**50**	**75**	**100**
49	49	73	97
48	48	71	94
47	47	69	91
46	46	67	88
45	**45**	**65**	**85**
44	44	63	82
43	43	61	79
42	42	59	76
41	41	57	73
40	**40**	**55**	**70**
39	39	53	67
38	38	51	64
37	37	49	61
36	36	47	58
35	**35**	**45**	**55**
34	34	43	52
33	33	41	49
32	32	39	46
31	31	37	43
30	**30**	**35**	**40**
29	29	33	37
28	28	31	34
27	27	29	31
26	26	27	28
25	**25**	**25**	**25**
24	24	24	24
23	23	23	23
22	22	22	22
21	21	21	21
20	**20**	**20**	**20**
19	19	19	19

Disability level %	Compensation according to variants no progression	A	B
18	18	18	18
17	17	17	17
16	16	16	16
15	**15**	**15**	**15**
14	14	14	14
13	13	13	13
12	12	12	12
11	11	11	11
10	**10**	**10**	**10**
9	9	9	9
8	8	8	8
7	7	7	7
6	6	6	6
5	**5**	**5**	**5**

2. Aesthetic damages
   If in the accident the insured suffered serious permanent disfigurement (aesthetic damage) which does not qualify for a lump-sum disability benefit under item (a) above but nevertheless constitutes a psychological prejudice which is certain to jeopardise his economic future or social status, the Insurer shall pay an indemnity equal to:
   - 10% of the insured sum stipulated in the policy if the insured's face is mutilated;
   - 5% of the insured sum stipulated in the policy if other usually visible parts of the body are mutilated.

   The indemnity for such damages shall not exceed CHF 20,000 per case.
3. Cost of professional retraining
   If, as a result of the same accident, the insured has to be retrained for another profession, the Insurer shall be liable, in addition to the benefits under items 1 and 2, for reasonable costs not covered by other insurers; such costs may not exceed CHF 20,000 per case.

Art. 17 Lump-sum in case of death

1. Entitlement to benefits
   If the accident causes the death of the insured, the Insurer shall pay the agreed lump-sum death benefit, subject to Article 20(3) of these General Terms and Conditions, to the beneficiaries in the following order:
   a. Surviving spouse / registered partner
      The surviving spouse or the registered partner is entitled to the lump-sum death benefit.
   b. Children
      The deceased's children under 18 or, if they are still studying or in apprenticeship, under 25, are entitled to a lump-sum death benefit in equal shares.
      Children who were dependent on the deceased for their education and maintenance at the time of his death are equated with his own children provided he supported them durably and at no charge. Failing one of the deceased's children, his share shall be paid to his heirs.

c. Common-law partner
   An unmarried or unregistered physical person who is a non-relative (also applies to same-sex partners) and who cohabited uninterruptedly with the deceased in a common-law marriage for the last five years before the death.
d. Other survivors if they cohabited with the insured at the time of his death:
   – to his parents, in equal shares;
   – failing them, to his brothers and sisters, in equal shares;
     If a sibling is already dead, his share shall be paid to his heirs.
   – if the insured has none of the above survivors, the Insurer shall only pay the share of burial costs not covered by another insurer up to 10% of the capital death benefit but not more than CHF 10,000.

2. Overlapping benefits
   Any disability benefits already paid for the consequences of the same accident (see Article 16 of the General Terms and Conditions) shall be deducted from the death benefits.
3. Fault on the part of a survivor
   Cash benefits payable to the relatives or survivors of the insured shall be reduced if the latter caused the realisation of the risk deliberately or by deliberately committing a crime or an offence.

Art. 18 Benefits in the form of an LAA/UVG excess pension

1. Disability pension
   – If provided for in the policy, the Insurer shall pay a disability allowance of 80% of the insured excess salary in the case of total disability. In the case of partial disability, the pension is reduced proportionately.
     Moreover, except for the provisions on supplemental pensions, the LAA/UVG is applicable. Notwithstanding, the entitlement to a pension ceases when the insured reaches AVS/AHV retirement age.
   – The Insurer reserves the right to redeem disability pensions of less than CHF 200 per month.
2. Survivor pensions
   If provided for in the policy, the Insurer shall pay the following survivor pensions:
   – 40% of the insured excess salary to the surviving spouse;
   – 15% of the insured excess salary for children having lost one parent;
   – 25% of the insured excess salary for children having lost both parents;
   – where pensions are payable to several survivors, no more than 70% of the insured excess salary in aggregate.
     Moreover, except for the provisions concerning supplemental pensions, the LAA/UVG shall apply.
   – The Insurer reserves the right to redeem disability pensions of less than CHF 200 per month.
3. Excess benefits
   a. The conjunction of benefits paid by different social and private insurers shall not result in excess benefits for the insured (not more than the cumulative amount of 90%).
      Only identical benefits with the same purpose, which are provided to the insured following the harmful event, are taken into account in calculating excess benefits.
   b. Excess benefits are when the social and private benefits which are legally due exceed, due to the realisation of the risk, the income that was supposedly due to the insured, additional costs and any income decreases suffered by relatives.
   c. Cash benefits are reduced by the amount of the excess benefits.
4. Fault on the part of a survivor
   Cash benefits payable to the relatives or survivors of the insured shall be reduced if the latter caused the realisation of the risk deliberately or by deliberately committing a crime or an offence.

Art. 19 Coverage of the reduction imposed by LAA/UVG accident insurance

1. If provided for in the policy, and in addition to the benefits specified therein, coverage of the reduction imposed by LAA/UVG insurance provides that the Insurer will supplement the LAA/UVG cash benefits when benefits are reduced due to an accident caused by negligence or in case of hazardous activities, except in the case of offences.
2. Article 22 of these terms and conditions remains reserved.
3. The Insurer may at any time redeem, at present value, pension benefits payable under the extended coverage supplementing LAA/UVG insurance. In that case, any claims of the insured in connection with the accident will be fully extinguished.
4. Pension benefits paid under extended coverage supplementing LAA/UVG insurance are not indexed.

Art. 20 Adjustment of entitlement to benefits when reaching the statutory AVS/AHV retirement age

The Insurer shall adjust benefits from the first day of the month after the month which the insured reaches AVS/AHV retirement age in, for cases ongoing at that time or for cases occurring afterwards as follows:

1. Daily allowance
   The daily allowance is paid during a maximum of six months.
2. Lump-sum disability benefit
   The insured sum is limited to the amount of the maximum LAA/UVG insured income without progression.
3. Lump-sum death benefit
   The insured sum is limited to the amount of the maximum LAA/UVG insured income.

Art. 21 Territorial validity

Coverage is valid worldwide within the limits specified above:

1. Emergency outpatient treatments and hospital stays during a stay abroad limited in time are covered provided they are necessary within the meaning of LAA/UVG insurance.
2. Cross-border workers are entitled to the same coverage than workers domiciled in Switzerland provided the outpatient treatment and/or hospital stay take place within a 100 km radius from the legal domicile.

3. The worker posted abroad is entitled to benefits for as long as he is entitled to LAA/UVG coverage or to accident insurance comparable to LAA/UVG and provided the outpatient treatment and/or hospital stay take place within a 100 km radius from the legal domicile.
4. During his incapacity for work, the insured person who wishes to travel abroad or the cross-border worker or worker posted abroad who wishes to leave the vicinity of his legal address (radius of 100 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 stay after having assessed the situation. In the absence of an agreement with the Insurer, daily allowance benefits will be refused during the stay abroad.

Art. 22 Excluded benefits

Are excluded from the insurance:
- cases of non-disclosure;
- cases of fraud or insurance fraud attempts;
- intentional damage;
- accidents caused unintentionally by the insured while committing an offence in particularly serious cases within the meaning of LAA/UVG insurance;
- non occupational accidents due to hazardous activities in particularly serious cases within the meaning of LAA/UVG insurance;
- accidents caused by the insured while committing a crime;
- accidents during earthquakes;
- the consequences of events of war:
  - in Switzerland;
  - abroad, unless the events catch the insured by surprise in the country where he is staying and provided the accident occurs no more than 14 days after the start of such events;
- accidents during military service abroad;
- participation in acts of terrorism or organised crime;
- damages caused by ionising rays of any kind. This exclusion does not apply to conditions caused by radiation treatments prescribed by a doctor in connection with an insured event

Art. 23 Reduction and denial of benefits

The Insurer waives its rights to reduce its benefits for all accidents insured by the policy and caused recklessly or through gross negligence within the meaning of the LAA/UVG legislation subject to Article 22 of these terms and conditions.
Cash benefits will be reduced mutatis mutandis to the LAA/UVG insurance:
- when the accident was caused while committing an offence;
- in case of participation in brawls and fights, unless the insured person was injured (by participants in the brawl or fight) as a bystander or while attempting to assist a helpless person;
- if the insured exposes himself to danger by seriously provoking a third party;
- if the insured participates in disturbances.

Benefits may be reduced or refused temporarily or definitively:
- if the policyholder or the insured person does not respect his obligations under Article 29 and 30 of these 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 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.

Art. 24 Recourse against liable third parties

Upon the occurrence of an insured event, the Insurer is subrogated, within the limits of the benefits provided by it, to the rights of the insured and his survivors against any third party liable for the event.

F. Premiums

Art. 25 Payment of premiums

The premium for the LAA/UVG supplemental insurance is calculated based on the insured's AVS/AHV salary or agreed salary. The Federal Law on Accident Insurance (LAA/UVG) and the relevant ordinances are also applicable.
1. The policyholder is the debtor of the premiums.
2. Premiums are payable within the time limit specified in the policy.
3. 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 and must correspond to the presumed effective premium.
4. If the premium or premium instalments are not paid when due, 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 and costs are not paid within the additional time limit, the Insurer's obligations shall be suspended thereafter.
   Claims arising during the suspension period will not be covered.
5. If the Insurer does not chase payment of the premium in arrears and expenses within two months following the expiry of the 14-day deadline, the contract will be deemed to be terminated.
6. If the salary declaration form is not supplied 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.

Art. 26 Adjustment of premium rates

The Insurer may adjust premium rates to allow for trends in costs and claims, or if there is a change in the classification of companies in tariff classes and levels pursuant to Article 92(5) LAA/UVG; adjustments shall be effective from the start of the following year.
The Insurer shall inform the policyholder of the new contractual terms no later than 25 days before the expiry of the insurance year. The policyholder shall then be entitled to terminate the amended contract for the end of the current insurance year.
To be valid, the notice of termination must be sent by registered letter received on or before 31 December. If the policyholder does not terminate the contract, the premium rate adjustments shall be deemed accepted.

Art. 27 Final premium settlement

The final premium statement will be prepared at the end of the year corresponding to the calendar year, based on the documentation provided by the policyholder or by an assessment of the rate by the Insurer itself.

Art. 28 Surplus-sharing

1. The agreed share of any surplus proceeding from the contract shall be paid to the policyholder, in accordance with the terms and conditions of the contract.
2. The accounting is done after the end of the accounting period but not before all losses during the period have been settled and indemnified.
3. If the 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 policy remains in force until the end of the accounting period.

G. Other provisions

Art. 29 Obligations of the policyholder

1. The policyholder shall inform the insureds about 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 insureds or on expiry of the policy.
2. Pursuant to the obligation to inform (Article 3 LCA/VVG), the policyholder is also required to inform insureds about the essential elements of the contract.
3. The employer shall notify the Insurer promptly as soon as he hears that one of his employees has had an accident which requires medical attention, causes an incapacity for work or results in the insured’s death.
4. The policyholder shall notify the Insurer immediately of the termination of the employment relationship of an employee who has an incapacity for work.
5. For the final invoicing, the policyholder shall provide the Insurer with the salary declaration form and, if requested, the insureds’ AVS/AHV statements.
6. The policyholder shall afford the Insurer, or the Insurer’s agents, 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 its obligations.
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 in the insured’s profession).

Art. 30 Obligations of the insured person

1. The insured shall notify his employer or the Insurer promptly of any accident requiring medical attention or causing an incapacity for work.
   If the insured dies as a result of the accident, this obligation is incumbent upon the survivors of the deceased who are entitled to benefits.
2. 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).
3. 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 his situation which could affect his entitlement to benefits (change in the degree of incapacity, registration to unemployment insurance, entitlement to third party benefits, etc.).
4. The insured shall release his attending practitioners from medical and professional secrecy vis à vis the Insurer’s medical advisor.
5. The insured must cooperate with the Insurer and with the third parties mandated by the Insurer (claims’ inspectors, officers, doctors, etc.). He shall follow their instructions, provide the requested documents and answer, fully and truthfully, any questions asked by the Insurer.
6. The insured must 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.
7. The insured is obliged to limit damages, including cooperate with social insurance institutions (disability insurance, accident insurance, military insurance, etc.).
8. 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.
9. At the latest three days following the beginning of the in-

capacity, the insured shall consult a licensed doctor at his practice and follow his instructions.

10. 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. 31 Change in insured risks

1. Aggravated risk
   - The policyholder shall promptly notify the Insurer in written form significant event (e.g. change in corporate business activities or in the insured's profession) liable to aggravate risks.
   - If he fails to do so, the Insurer shall no longer be bound by the contract.
   - Aggravated risks which are duly notified by the policyholder shall be covered by the Insurer. The Insurer may, however, terminate the contract within 14 days of receiving the policyholder's notification. Should this be the case, coverage ceases 14 days after the Insurer receives the notice of termination.
   - Additional premiums, if any, are due from the outset of the aggravated risk.
2. Premiums 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 a decisive change in the composition of the circle of insureds, provided that variations in payroll amount to 10 % or more.

Art. 32 Assignment and pledging of benefits

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

Art. 33 Broker clause

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

Art. 34 Notices

1. Notices shall be addressed to the Insurer's general administration or to one of its official agencies.
2. Notices given 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. 35 Place of performance

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

Art. 36 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 work in Switzerland.